Oregon Health Authority

2023 Compliance Monitoring Review Report

for

Cascade Health Alliance, LLC.

December 2023

HSAG HEALTH SERVICES ADVISORY GROUP

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1. Overview

Background

According to federal requirements located within Title 42 of the Code of Federal Regulations (42 CFR) §438.358, the State, an agent that is not a coordinated care organization (CCO), or its external quality review organization (EQRO) must conduct a review within a three-year period to determine a Medicaid CCO's compliance with the standards set forth in 42 CFR §438—Managed Care Subpart D, the disenrollment requirements and limitations described in §438.56, the enrollee rights requirements described in §438.100, the emergency and poststabilization services requirements described in §438.114, and the quality assessment and performance improvement requirements described in §438.330.

To comply with the federal requirements, the State of Oregon, Oregon Health Authority (OHA) contracted with Health Services Advisory Group, Inc. (HSAG) as its EQRO to:

- Conduct the calendar year (CY) 2023 compliance monitoring reviews (CMRs) of each of its contracted CCOs, across six standards for the review period of January 1, 2022–December 31, 2022.
- Prepare a report of findings with respect to each CCO's performance strengths and areas requiring corrective action or performance improvement.
- Conduct a follow-up reevaluation of any CCOs that require implementation of corrective actions in order to attain full compliance.

HSAG is an EQRO that meets the competency and independence requirements of 42 CFR §438.354(b) and (c). HSAG has extensive experience and expertise in conducting reviews to evaluate managed care organization, prepaid inpatient health plan, prepaid ambulatory health plan, and primary care case management entity compliance with the Medicaid managed care regulations and associated State contract requirements. HSAG uses the information and data it derives from the reviews to reach conclusions and make recommendations about the quality, timeliness, and accessibility of care and services the State's CCOs provide. Table 1-1 depicts the assignment of the standards reviewed in CY 2023 to the domains of care.

Table 1-1—Assignment of CMR Standards to the Quality, Timeliness, and Access Domains

CMR Standard	Quality	Timeliness	Access
Standard III—Coordination and Continuity of Care	✓	✓	✓
Standard IV—Coverage and Authorization of Services		✓	✓
Standard VII—Member Rights and Protections	✓		
Standard X—Grievance and Appeal Systems	✓	✓	✓
Standard XIV—Member Information		✓	✓
Standard XVI—Emergency and Poststabilization Services		✓	✓

In CY 2023, OHA contracted with 16 CCOs to provide Medicaid-covered primary and acute physical, behavioral, and oral health services to over 1.2 million Oregon Health Plan (OHP) members. The following sections describe how the review was conducted and summarize the findings from the CY 2023 CMR.

2. Review Methodology

Introduction

The CMRs assess CCO compliance with federal compliance review standards outlined in 42 CFR §438.358(b)(1)(iii) and related State contract requirements in accordance with the Centers for Medicare & Medicaid Services (CMS) External Quality Review (EQR) *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019 (EQR Protocol 3),[2-1] to create the process, tools, and interview questions used for the CY 2023 CMR.

Objectives

The objective of the CMRs is to provide meaningful information to OHA and the CCOs regarding:

- The CCOs' compliance with federal managed care regulations, Oregon Administrative Rules (OARs), and contract requirements with the standard areas reviewed.
- Strengths, opportunities for improvement, recommendations, or required actions to bring the CCOs into compliance with federal managed care regulations and State requirements with the standard areas reviewed.
- The quality, timeliness, and accessibility of care and services furnished by the CCOs, as addressed within the specific areas reviewed.
- Possible additional interventions recommended to improve the quality of the CCOs' care provided and services offered related to the areas reviewed.

To accomplish its objective and based on the results of collaborative planning with OHA, HSAG developed data collection tools to assess and document each CCO's compliance with certain federal Medicaid managed care regulations, State rules, and the associated OHA contractual requirements. Table 2-1 describes the requirements that address the performance areas included in this year's review (CY 2023).

[2-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Mar 6, 2023.

Table 2-1—CMR Three-Year Cycle

CMR Standard	Federal Requirements Included	Year One (CY 2023)	Year Two (CY 2024)	Year Three (CY 2025)
Standard I—Availability of Services	42 CFR §438.206		✓	
Standard II—Assurances of Adequate Capacity and Services	42 CFR §438.207		✓	
Standard III—Coordination and Continuity of Care	42 CFR §438.208	✓		
Standard IV—Coverage and Authorization of Services	42 CFR §438.210	✓		
Standard V—Provider Selection	42 CFR §438.12; 42 CFR §438.214		✓	
Standard VI—Subcontractual Relationships and Delegation	42 CFR §438.230		✓	
Standard VII—Member Rights and Protections	42 CFR §438.100– 42 CFR §438.102	✓		
Standard VIII—Confidentiality	42 CFR §438.224			✓
Standard IX—Enrollment and Disenrollment	42 CFR §438.3 42 CFR §438.56			✓
Standard X—Grievance and Appeal Systems	42 CFR §438.228; 42 CFR §438.400– 42 CFR §438.424	✓		
Standard XI—Practice Guidelines	42 CFR §438.236		✓	
Standard XII—Quality Assessment and Performance Improvement	42 CFR §438.330			✓
Standard XIII—Health Information Systems, including Information Systems Capabilities Assessment (ISCA)	42 CFR §438.242			✓
Standard XIV—Member Information	42 CFR §438.10	✓		
Standard XVI—Emergency and Poststabilization Services	42 CFR §438.114	✓		

Table 2-2—CY 2023 CMR Standards and Descriptions

CMR Standard	Description
Standard III—Coordination and Continuity of Care *42 CFR §438.208*	Requires the CCO to have policies and procedures that ensure each member has an ongoing source of appropriate care that is coordinated among medical providers and other entities serving the member, and is compliant with applicable privacy requirements. The CCO must conduct health risk screenings and an assessment/reassessment of prioritized populations and members with special health care needs (SHCN) for intensive care coordination (ICC) services.
Standard IV—Coverage and Authorization of Services *42 CFR §438.210*	Requires the CCO to have an effective system to review, approve, or deny authorization requests while consistently applying the use of medical necessity criteria. The CCO must have policies and procedures related to coverage and authorization ensuring decision-makers have the appropriate level of expertise, and that notification of decisions are provided in a timely fashion.
Standard VII—Member Rights and Protections *42 CFR §438.100*	Requires the CCO to inform its members, subcontractors, and network providers of members' rights. The CCO must ensure that member rights are respected and allowed to be exercised freely without affecting the treatment of members. The CCO's policies, procedures, and member information must include the State and federal requirements for advance directives.
Standard X—Grievance and Appeal Systems *42 CFR §438.228*	Requires the CCO to maintain a system for grievances and appeals that includes required member information and communications. The CCO's policies and procedures address how grievances are filed and processed, the appeals process related to adverse benefit determinations, assistance with the grievance and appeal process, time frames for issuing acknowledgement notices and notices of adverse benefit determination (NOABDs), as well as an expedited appeal process.
Standard XIV—Member Information *42 CFR §438.10*	Requires the CCO to provide information to its members in a way that is easy to access and understand, including the provision of materials in alternative formats and languages. The CCO must have a mechanism to communicate significant changes in a timely manner. The CCO's policies and procedures address how the CCO ensures compliance with furnishing each member with required information within the state-established time frames.
Standard XVI—Emergency and Poststabilization Services *42 CFR §438.114*	Requires the CCO to ensure access to emergency and poststabilization services without prior authorization. The CCO's policies and procedures address coverage and payment for emergency and poststabilization services.

The information and findings that resulted from HSAG's review of standards and files were used by OHA and each CCO to:

- Evaluate the degree to which the CCO's operations comply with State contracts and federal Medicaid managed care requirements.
- Evaluate the CCO's organizational strengths and identify areas for improvement.
- Identify and monitor the CCO's implementation of interventions to improve the CCO's compliance with quality, timeliness, and accessibility of health care services provided to members.

Compliance Monitoring Review Activities and Technical Methods of Data Collection

Before beginning the CMR, HSAG developed data collection tools to document the review. The requirements in the tools were selected based on applicable federal and State regulations and requirements set forth in the contract between OHA and the CCOs as they relate to the scope of the review. HSAG conducted the following preliminary review (pre-site visit), site visit, and post-site visit activities:

Preliminary Review (Pre-Site Visit) Activities

Preliminary review activities included:

- Providing the CMR Protocol, CMR tools, and applicable guidance to the CCOs.
- Hosting a pre-review technical assistance session with the CCOs.
- Receiving CMR documentation submissions from the CCOs, including complete universes of cases for selected file reviews.
- Conducting a desk review of key documents and other information submitted to HSAG by the CCOs, and from OHA, as applicable. The desk review enables HSAG reviewers to increase their knowledge and understanding of the CCO's operations, identify areas needing clarification, and begin compiling information before the site visit.
- Scheduling the site visit, either in person or virtual.
- Distributing the site visit meeting agenda to the CCO to facilitate preparation for HSAG's site visit.
- Conducting a file review of key data elements to evaluate how each organization implemented a number of the requirements for certain managed care administrative functions by reviewing samples of:
  - Appeal records.
  - Grievance records.
  - Service authorization denials.
  - Care management and service coordination records.

Site Visit Activities

Site visit activities included:

- Conducting an opening conference, with introductions and a review of the agenda and logistics for HSAG's site visit activities.
- Reviewing additional documents requested by HSAG and made available by the CCOs during the interview sessions.
- Reviewing applicable data systems that the CCOs uses in its operation to support standards under review, including but not limited to, utilization management (UM), care coordination, etc.
- Reviewing selected member clinical/nonclinical records in support of file reviews associated with regulatory standards.
- Conducting interviews with the CCOs' key administrative and program staff members.
- Conducting a closing conference where HSAG reviewers summarize their preliminary findings and next steps.

Post-Site Visit Activities

Post-site visit activities included:

- Collecting supplemental information identified during the site visit.
- Compiling data and information obtained from the desk review and site visit interviews.
- Analyzing and aggregating all review findings to produce final compliance determinations.
- Preparing and publishing draft and final compliance reports.

Description of Data Obtained

To assess the CCO's compliance with federal regulations, State rules, and contract requirements, HSAG obtained information from a wide range of written documents produced by the CCOs, including, but not limited to:

- Committee meeting agendas, minutes, and handouts.
- Written policies and procedures.
- Management/monitoring reports and audits.
- Staff training materials and documentation of training attendance.
- Narrative and/or data reports across a broad range of performance and content areas.
- CCO-maintained records for service authorization denials.
- Member handbooks, informational materials, the provider directory, and the provider manual.

- Applicable sample correspondence or template communications.
- Member-level clinical and nonclinical files (e.g., care management records).

HSAG obtained additional information for the CMR through interactions, discussions, and interviews with the CCO's key staff members.

Table 2-3 lists the major data sources HSAG used to determine the CCO's performance in complying with requirements and the time period to which the data applied.

Table 2-3—Description of the CCO's Data Sources

Data Obtained	Time Period to Which the Data Applied
Documentation submitted for HSAG's desk review and additional documentation available to HSAG during the site visit.	January 1, 2022–December 31, 2022*
Clinical and nonclinical member records submitted for HSAG's file review.	January 1, 2022–December 31, 2022*
Information obtained through interviews.	July 1, 2023–September 30, 2023

*Data obtained for the record reviews may exceed the time period specified depending on the resolution time frame.

Data Aggregation and Analysis

HSAG reviewers used ratings of *Met*, *Partially Met*, and *Not Met* to indicate the degree to which the CCO's performance complied with the requirements. This scoring methodology is in alignment with CMS' EQR Protocol 3. HSAG compiled all submitted documentation and conducted a final review, considering the intent of the regulations, and applied a rating for each element based on the following definitions:

Met indicates full compliance, defined as:

- All documentation listed under a regulatory provision, or component thereof, is present; and
- CCO staff provide responses to reviewers that are consistent with each other and with the documentation.

Partially Met indicates partial compliance, defined as:

- There is compliance with all documentation requirements, but CCO staff are unable to consistently articulate evidence of compliance during interviews; or
- CCO staff can describe and verify the existence of compliant practices during the interview, but documentation is found to be incomplete or inconsistent with practice.

Not Met indicates noncompliance, defined as:

- No documentation is present, and staff members have minimal or no knowledge of processes or issues addressed by the regulatory provisions; or
- No documentation is present and staff members have little or no knowledge of processes or issues that comply with key components (as defined by OHA) of a multi-component regulatory provision, regardless of compliance determinations for remaining, non-key components of a regulatory provision.

From the scores it assigned for each of the requirements, HSAG calculated a total percentage-of-compliance score for each of the six standards and an overall percentage-of-compliance score across the six standards. HSAG calculated the total score for each standard by totaling the number of *Met* (1 point) elements, the number of *Partially Met* (0.5 points) elements, and the number of *Not Met* (0 points) elements, then dividing the summed score by the total number of applicable elements for that standard.

HSAG determined the overall percentage-of-compliance score across the areas of review by following the same method used to calculate the scores for each standard (i.e., by summing the total values of the scores and dividing the result by the total number of applicable elements).

How Data Were Aggregated and Analyzed

To draw conclusions about the quality, timeliness, and accessibility of care and services the CCOs provided to members, HSAG aggregated and analyzed the data resulting from its pre-site visit and site visit review activities. The data that HSAG aggregated and analyzed included the following:

- Documented findings describing the CCO's progress in achieving compliance with State and federal requirements.
- Scores assigned to the CCO's performance for each element.
- The total percentage-of-compliance score calculated for each of the standards.
- The overall percentage-of-compliance score calculated across the standards.
- Documentation of the actions required to bring performance into compliance with the requirements that HSAG assigned a score of *Partially Met* and *Not Met*.

Based on the results of the data aggregation and analysis, HSAG prepared and forwarded preliminary findings to the CCOs and draft reports to OHA for their review and comment prior to issuing final reports.

3. Summary of Results

Compliance With Review Standards

HSAG's findings for the CY 2023 CMR were determined from its:

- Desk review of the documents Cascade Health Alliance, LLC. (CHA) submitted to HSAG prior to the site visit portion of the review.
- Service authorization denials, care/service coordination, member grievances, and member appeal file reviews conducted prior to the site visit portion of the review.
- Site visit activities that included reviewing additional documents and records, interviewing key CHA administrative and program staff members, and system demonstrations.

For each of the individual elements (i.e., requirements) within each standard, HSAG assigned a score of *Met*, *Partially Met*, or *Not Met* based on the results of its findings. HSAG then calculated a total percentage-of-compliance score for each of the six standards and an overall percentage-of-compliance score across the six standards.

The following methodology was used to indicate the confidence level assigned following HSAG's assessment of CHA's operational structure and implementation of documented processes to determine the degree to which the CCO achieved compliance with the standards reviewed in CY 2023.

- ***High Confidence*** = Compliance Score ≥ 95 percent.
- ***Moderate Confidence*** = Compliance Score ≥ 85 percent and < 95 percent.
- ***Low Confidence*** = Compliance Score ≥ 75 percent and < 85 percent.
- ***No Confidence*** = Compliance Score < 75 percent.

Table 3-1 presents a summary of CHA's performance results, including a comparison to the CCO's previous performance in the standards reviewed (CY 2020) and the statewide CCO compliance score. Details of the scoring methodology are described in *Section 2. Review Methodology*. Due to the small number of elements associated with individual standards, a single *Partially Met* or *Not Met* rating may lead to substantive changes in the confidence level. As such, results at the standard level should be viewed as informational in support of the CCO's overall compliance score and confidence level.

Table 3-1—Standards and Compliance Scores for CHA

Standard	Total # of Elements	# Met	# Partially Met	# Not Met	CY 2023 Compliance Score	CY 2023 Confidence Levels	CY 2020 Compliance Score	Statewide CY 2023 CCO Compliance Score
Standard III—Coordination and Continuity of Care	9	5	3	1	72.2%	*No Confidence*	80.0%	85.1%
Standard IV—Coverage and Authorization of Services	18	13	5	0	86.1%	*Moderate Confidence*	94.0%	70.1%
Standard VII—Member Rights and Protections	5	2	3	0	70.0%	*No Confidence*	89.0%	69.4%
Standard X—Grievance and Appeal Systems	27	17	10	0	81.5%	*Low Confidence*	89.0%	85.2%
Standard XIV—Member Information	22	11	7	4	65.9%	*No Confidence*	90.0%	80.0%
Standard XVI—Emergency and Poststabilization Services	12	8	4	0	83.3%	*Low Confidence*	-	85.4%
Overall Compliance Score	**93**	**56**	**32**	**5**	**77.4%**	***Low Confidence***	**88.0%**	**80.2%**

***Total # of Elements*:** The total number of elements in each standard.

***Overall Compliance Score*:** The percentages obtained by adding the number of elements that received a score of *Met* to the weighted (multiplied by 0.50) number that received a score of *Partially Met*, then dividing this total by the total number of applicable elements.

The findings from the CMR show how well the CCO interpreted State and federal regulations and the CCO contract requirements, and developed the necessary policies, procedures, and plans to carry out the required functions of the CCO. HSAG assigned a *Low Confidence* level to CHA's compliance with all regulatory requirements reviewed based on the overall compliance score of 77.4 percent. HSAG also assigned a confidence level to each standard reviewed for CHA in CY 2023. HSAG assigned the CCO a *Moderate Confidence* level for *Coverage and Authorization of Services*; a *Low Confidence* level for *Grievance and Appeal Systems* and *Emergency and Postabilization Services*; and a *No Confidence* level for *Coordination and Continuity of Care*, *Member Rights and Protections*, and *Member Information*. None of the standards reviewed were assigned a *High Confidence* level. Of the 93 elements, CHA received *Met* scores for 56 elements, *Partially Met* scores for 32 elements, and *Not Met* scores for five elements.

The overall CY 2023 compliance score of 77.4 percent demonstrated declined performance by 10.6 percentage points compared to the overall score of 88.0 percent from the CY 2020 CMR. Additionally, CHA's scores declined in all standards compared to the previous review conducted in CY 2020. CHA performed below the overall statewide CCO average by 2.8 percentage points for the CY 2023 CMR. Of note, CHA scored lower than the statewide CCO average compliance score for *Grievance and Appeal Systems, Emergency and Postabilization Services, Coordination and Continuity of Care*, and *Member Information*.

The areas with opportunities for improvement from the CY 2023 CMR were related *to Coordination and Continuity of Care, Coverage and Authorization of Services, Member Rights and Protections, Grievance and Appeal Systems, Member Information*, and *Emergency and Poststabilization Services*, as these areas received performance scores of less than 100 percent. These findings suggest that CHA did not consistently establish and implement the necessary policies, procedures, and plans to operationalize the required elements of its contract and regulatory provisions, and did not consistently demonstrate compliance with the expectations of the contract. Further, CHA staff interviews showed that staff members were not consistently knowledgeable about the requirements of the contract, and the policies and procedures that the CCO employed to meet contractual and regulatory requirements.

Detailed findings for each element within each standard reviewed, including program enhancements and required actions, are documented in *Appendix A. Evaluation Tool*.

Summary of Overall Strengths and Areas Requiring Improvement

Standard III—Coordination and Continuity of Care

Performance Strengths	**Strength:** No strengths were identified for the *Coordination and Continuity of Care* standard.
Area(s) Requiring Improvement	**Area(s) requiring improvement:** The CCO received a score of 72.2 percent in the *Coordination and Continuity of Care* standard due to a lack of operational structure and failure to appropriately screen and assess/reassess members for care management and intensive care coordination services. **[Quality, Timeliness, and Access]** **Rationale:** The CCO's policies and procedures did not align with State requirements. Additionally, the CCO failed to demonstrate the implementation of health risk screenings according to State requirements. The CCO also did not demonstrate mechanisms for ongoing monitoring of outreach and assessment completions to ensure compliance with established time frames. **Required action(s):** The CCO must revise its policies and procedures to align with State requirements. The CCO must also demonstrate implementation of appropriate initial health risk screenings, assessments, and reassessments according to federal and State requirements.

Standard IV—Coverage and Authorization of Services

Performance Strengths

Strength: No strengths were identified for the *Coverage and Authorization of Services* standard.

Area(s) Requiring Improvement

Area(s) requiring improvement: The CCO received a score of 86.1 percent in the *Coverage and Authorization of Services* standard due to a lack of operational structure and failure to demonstrate appropriate implementation, impacting the CCO's ability to adhere to federal and State requirements for authorizing services and to ensure proper and timely notification of adverse benefit determinations. **[Quality, Timeliness, and Access]**
Rationale: The CCO's policies and procedures did not align with federal and State requirements. Additionally, the CCO demonstrated reversing service authorization decisions outside the appeal process. The CCO also failed to adhere to requirements for required content and time frames for notification of adverse benefit determinations.
Required action(s): The CCO must revise its policies and procedures to align with federal and State requirements. The CCO must demonstrate adherence to federal and State requirements for authorization of services, and required content and time frames for notification of adverse benefit determination.

Standard VII—Member Rights and Protections

Performance Strengths

Strength: No strengths were identified for the *Member Rights and Protections* standard.

Area(s) Requiring Improvement

Area(s) requiring improvement: The CCO received a score of 70.0 percent in the *Member Rights and Protections* standard due to a lack of operational structure and failure to demonstrate implementation of an established process, impacting the CCO's ability to ensure that member rights are respected and allowed to be exercised freely without affecting the treatment of members, advance directive requirements are met, and members are notified of their rights as required by federal and State requirements. **[Quality and Access]**
Rationale: The CCO's policies and procedures and member- and provider-facing materials did not align with federal and State requirements.
Required action(s): The CCO must revise its policies and procedures and member- and provider-facing materials to align with federal and State requirements.

Standard X—Grievance and Appeal Systems

Performance Strengths

Strength: No strengths were identified for the *Grievance and Appeal Systems* standard.

Area(s) Requiring Improvement

Area(s) requiring improvement: The CCO received a score of 81.5 percent in the *Grievance and Appeal Systems* standard due to a lack of operational structure and failure to demonstrate appropriate implementation, impacting the CCO's ability to ensure member grievances and appeals are addressed and responded to appropriately. **[Quality, Timeliness, and Access]**
Rationale: The CCO's policies and procedures did not align with federal and State requirements. Additionally, the CCO failed to adhere to requirements for time frames for acknowledging and responding to grievances and appeals, and the readability and required content of notices. The CCO also failed to communicate grievance and/or appeal requirements to members, providers, and subcontractors.
Required action(s): The CCO must revise its policies and procedures to align with federal and State requirements. The CCO must also demonstrate adherence to federal and State requirements for time frames for acknowledging and responding to grievances and appeals, and the readability and required content of notices. The CCO must also demonstrate implementation of federal and State requirements within communications to members, providers, and subcontractors.

Standard XIV—Member Information

Performance Strengths

Strength: No strengths were identified for the *Member Information* standard.

Area(s) Requiring Improvement

Area(s) requiring improvement: The CCO received a score of 65.9 percent in the *Member Information* standard due to a lack of operational structure and failure to demonstrate implementation of an established process, impacting the CCO's ability to ensure proper member communication. **[Quality, Timeliness, and Access]**
Rationale: The CCO's policies and procedures and member-facing materials, including the member handbook, member notices, CCO formulary, and provider directory, did not align with federal and State requirements.
Required action(s): The CCO must revise its policies, procedures, and member-facing materials to align with federal and State requirements.

Standard XVI—Emergency and Poststabilization Services

Performance Strengths	**Strength:** No strengths were identified for the *Emergency and Poststabilization Services* standard.
Area(s) Requiring Improvement	**Area(s) requiring improvement:** The CCO received a score of 83.3 percent in the *Emergency and Poststabilization Services* standard due to a lack of operational structure to ensure emergency and poststabilization services are covered appropriately. **[Timeliness and Access]** **Rationale:** The CCO failed to demonstrate plan documents (i.e., policies and procedures, the provider manual, and the member handbook) appropriately define "emergency and poststabilization services" and communicate the appropriate requirements. **Required action(s):** The CCO must revise the applicable plan documents to define "emergency and poststabilization services" and communicate the appropriate requirements.

CY 2022 Improvement Plan Review

CHA was required to implement an Improvement Plan (IP) for all elements scored *Partially Met* or *Not Met* during the CY 2022 CMR and continue to address unresolved findings from previous CMRs. The CCO was expected to fully resolve all findings and demonstrate compliance with regulatory requirements prior to the CY 2023 CMR. To ensure the CCO had implemented plans of action to remediate the CMR findings, HSAG conducted follow-up reviews to evaluate the CCO's compliance with requirements.

HSAG used the following criteria to evaluate the sufficiency of the required actions and determine if the IP elements were resolved:

- The completeness of the IP document in addressing each required action and assigning a responsible individual, a timeline/completion date, and specific actions/interventions that the organization will implement to bring the element into compliance.
- The extent to which the planned activities/interventions bring the organization into compliance with the requirement.
- The timeliness of the CCO's efforts to correct the deficiency.

Table 3-2 presents CHA's summary of findings for the CY 2022 IP review. HSAG's evaluation of CHA's approach to addressing the 20 IP findings issued during CY 2022 and unresolved findings from CY 2021 revealed nine findings remain unresolved, indicating continued noncompliance with State and federal regulatory requirements.

Table 3-2—Summary of Findings for CHA's CY 2022 IP Review

Standard	Total # of Findings	Total # of Resolved Findings	Total # of Unresolved Findings	Total % of Unresolved Findings
Standard I—Availability of Services***	4	2	2	50.0%
Standard II—Assurances of Adequate Capacity and Services***	2	1	1	50.0%
Standard III—Coordination and Continuity of Care*	N/A	N/A	N/A	N/A
Standard IV—Coverage and Authorization of Services*	N/A	N/A	N/A	N/A
Standard V—Provider Selection***	5	3	2	40.0%
Standard VI—Subcontractual Relationships and Delegation***	N/A	N/A	N/A	N/A
Standard VII—Member Rights and Protections*	N/A	N/A	N/A	N/A
Standard VIII—Confidentiality	N/A	N/A	N/A	N/A
Standard IX—Enrollment and Disenrollment	4	2	2	50.0%
Standard X—Grievance and Appeal Systems*	N/A	N/A	N/A	N/A
Standard XI—Practice Guidelines***	N/A	N/A	N/A	N/A
Standard XII—Quality Assessment and Performance Improvement	3	1	2	66.7%
Standard XIII—Health Information Systems, including ISCA	2	2	0	-
Standard XIV—Member Information*	N/A	N/A	N/A	N/A
Standard XVI—Emergency and Poststabilization Services**	N/A	N/A	N/A	N/A
Total	**20**	**11**	**9**	**45.0%**

* Standards assessed during the CY 2020 CMR and reassessed in CY 2023. Gray shading indicates the CY 2023 IP may include additional findings for these standards identified during this year's CMR. Unresolved findings represented for these standards indicate the CCO has remained out of compliance since the CY 2020 CMR.

** Standard initially assessed under Standard IV—Coverage and Authorization of Services during the CY 2020 CMR and reassessed in CY 2023. Gray shading indicates the CY 2023 IP may include additional findings for these standards identified during this year's review. Unresolved findings represented for this standard indicate the CCO has remained out of compliance since the CY 2020 CMR.

***Standards assessed during the CY 2021 CMR. Unresolved findings represented for these standards indicate the CCO has remained out of compliance since the CY 2021 CMR.

4. Improvement Plan Process

CHA is required to submit an IP addressing all elements scored *Partially Met* or *Not Met* during the CY 2023 CMR. For each element that requires corrective action, the CCO should use the CCO-specific prepopulated CY 2023 IP tool to identify the actions(s) taken to achieve compliance with the requirement, the individual(s) responsible, and the timelines for completing the planned activities. Implementation of interventions identified in the IP should begin immediately to resolve findings and bring the organization into compliance with federal and State requirements. The completed IP and evidence of implementation must be submitted with the CY 2024 CMR pre-site visit documentation.

HSAG will review the CCO's IP, evidence of implementation for resolution of the CY 2023 findings, and any unresolved findings from previous reviews. Results of HSAG's assessment will be included in the CY 2024 CMR report. The CCO is encouraged to contact HSAG to schedule a technical assistance call to review findings and ensure proposed interventions will successfully resolve areas of noncompliance.

Appendix A. Evaluation Tool

Following this page is the completed compliance review tools HSAG used to evaluate CHA's performance for each requirement.

Standard III—Coordination and Continuity of Care

Standard III—Coordination and Continuity of Care (42 CFR §438.208)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
1. The CCO implements procedures to deliver care and coordinate services for all members, which include ensuring that each member has an ongoing source of care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the services accessed by the member. a. The member must be provided information on how to contact their designated person or entity. *42 CFR § 438.208(b)(1)* *Contract: Exhibit B Part 4 (2)(l)* *OAR 410-141-3860 (6)(b)*	**Suggested Documents:** • Care Coordination and/or Care Management Program Descriptions • Care Coordination and/or Care Management policies and procedures • Member Welcome Letter or other outreach letter • Member Handbook **Documents Submitted for Desk Review:** • Access.to.care.PP06002 (Sections 1.1, 4.2,4.2.1-4.2.2, 4.6, 4.6.1-4.6.3, 4.9, 4.10, 4.10.1.2.) • Care.Coordination.PP06003 (Sections 1.1.1-1.1.2, 3.1-3.3, 4.1, 4.4, 4.7-4.8, 4.11, 4.11.1-4.11.3) • Care.Coordination.PP03003.01 (Sections: 3.1,3.2,3.2.1-3.2.3) • Assessment.Tool.for.Developing.Care.Plan.DP06008 • Cascade Health Alliance Member Handbook: Section: – Quick Guide: Who to Call, Questions or Need Help?, Dental Questions or Help?, Pg. 27-28 – Transitional/Continuity of Care, Paragraph 1, Pg. 28 – Care Coordination and Other Services, Pg. 30) • Welcome to CM letter template (Paragraph II, signature block)	☒ Met ☐ Partially Met ☐ Not Met

Standard III—Coordination and Continuity of Care (42 CFR §438.208)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	• Description of Transition of Care for Member: https://www.cascadehealthalliance.com/for-members/transition-of-care/ • Directions to Member in how to find a Provider:https://www.cascadehealthalliance.com/for-members/find-a-provider/	

HSAG Findings: The CCO's *Care Coordination* policy outlined the CCO's process for assisting members in accessing providers and coordinating health services for members, including case management, transitional care, intensive care case management (ICCM), which was detailed further in the *Intensive Care Coordination (ICC) and Case Management* policy. The *Care Coordination* policy included the CCO's screening process, prioritized populations, and care coordination programs, such as Care Management, Condition Management, Transition of Care, Short Term Needs, and Maternity Care. The CCO also submitted its documented clinical pathways that outlined each care coordination program. Finally, the *Behavioral Health Care Coordination* policy outlined the CCO's process for coordinating care specific to behavioral health needs and stated that the policy was to be applied in addition to the ICCM, care coordination, and health risk assessment (HRA) processes.

The CCO's Care Coordination–Transitions of Care Provider Monitoring Process described processes for monitoring provider participation in transitions of care between settings of care and addressed noncompliance reporting and remediation.

The Welcome to Case Management letter to the members provided their care manager name and contact information. The letter stated the care manager answered the members' questions and helped them find the care that they need. It also stated that the care manager would make a care plan for members that would be shared with their provider. In addition, the New Member Welcome Letter informed members that their identification card and member handbook were included, instructed them to notify the CCO if they are currently seeing a doctor, and offered to help them find a provider if they do not have one.

Note: The *Care Coordination* policy has not been reviewed/approved since 07/22/2020, and the Care Coordination–Transitions of Care Provider Monitoring Process has not been reviewed/approved since 10/25/2019. This requirement was *Met.*

Required Actions: None.

Recommendations: HSAG also recommends that the CCO ensure the *Care Coordination* policy and the Care Coordination–Transitions of Care Provider Monitoring Process are reviewed and dated in accordance with its internal process, outlined in the CCO Overview Form, which indicated policies are reviewed annually. This recommendation applies to all elements that document a review of the previously mentioned policies.

Standard III—Coordination and Continuity of Care (42 CFR §438.208)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
2. The CCO implements procedures to coordinate services the CCO furnishes the member: a. Between settings of care, including appropriate discharge planning for short term and long-term hospital and institutional stays; b. With the services the member receives from any other MCE; c. With the services the member receives in FFS Medicaid; and d. With the services the member receives from community and social support providers. *42 CFR § 438.208(b)(2)* *Contract: Exhibit B Part 4 (1)(c)* *Contract: Exhibit M (11)(b)* *OAR 410-141-3860 (3)*	**Suggested Documents:** • Policies and procedures that address care coordination and/or continuity of care for services outlined in the requirement • Processes or workflows for coordinating with other entities (outlined in the requirement) and identification of responsibilities • One example showing the CCO coordinating care with each of the following entities listed in letters (a) through (d) of the requirement **Documents Submitted for Desk Review:** • Care.Coordination.PP06003 - pg. 3, section 4.12.1 • Care.Coordination.PP06003.01 • BH Care Coordination Tracking Example • CEFP Care Management Meeting Tracking Example • KOD Care Management Meeting Tracking Example • Care Coordination Services description for Members, CHA Website: https://www.cascadehealthalliance.com/for-members/member-benefits/care-coordination-services/ • Find a Provider CHA Website Example: • https://www.cascadehealthalliance.com/for-members/find-a-provider/ • CHA APD IDT referral form • SNF 2a Example 1 • SNF 2a Example 2 • Transition to Open Card Example 2c	☒ Met ☐ Partially Met ☐ Not Met

Standard III—Coordination and Continuity of Care (42 CFR §438.208)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
HSAG Findings: The CCO's *Care Coordination Policy* outlined transitional care coordination, including appropriate discharge planning for short-term and long-term hospital and institutional stays, working with providers, community resources, and any applicable State agencies to ensure members' needs were met. The policy stated that the CCO would coordinate with any other managed care organization, prepaid inpatient health plan, or prepaid ambulatory health plan to confirm the services the members were receiving, and then incorporated those services into the transition/care plan. The policy described the "warm-handoff" process between CCOs to facilitate continuity of care of the current care plan and how the CCO's designated case manager created a new care plan to meet the current and future needs of its members. The policy stated that the case manager monitored required participation of hospital staff, primary care, and specialists for facility transfers and discharges. Although the policy did not specifically describe the coordination of services for members receiving services in fee-for-service (FFS) Medicaid, the CCO's policy did address working with applicable State agencies and members receiving Medicaid-funded long-term services and supports (LTSS) meeting the intent of the requirement. The *Intensive Care Coordination and Case Management* policy addressed care coordination strategies to enhance communications across all settings, including coordination with external partners. The policy also included coordinating care between settings, care received by another health plan, and coordinating services with community and social support providers. In addition, the CCO's Transitions of Care Provider Monitoring Process described how case management and behavioral health staff followed and facilitated transitions of care, including short-term and long-term acute care, intermediate care, and all other institutional stays. The CCO provided case examples for transitions between facilities, from facility and institutional stays to the community and from another CCO. This requirement was *Met*.		
Required Actions: None.		
Recommendations: Although the CCO met the intent of the requirement, HSAG recommends that the CCO update its *Care Coordination* policy to identify those services members receive through Medicaid FFS.		
3. The CCO implements procedures to make a best effort to conduct an initial health risk screening, which shall include a screening for behavioral health issues, of each new member's needs: a. Within 90 days of the effective date enrollment; or b. Within 30 days after the effective date of enrollment when the member is referred, receiving Medicaid-funded long-term care,	**Suggested Documents:** • Initial health risk screening policies and procedures • Description of need stratification mechanism used to identify members receiving LTSS or members of a priority population (as defined in OAR 410-141-3870 (2)) • Sample of the initial health risk screening form/template	☐ Met ☒ Partially Met ☐ Not Met

Standard III—Coordination and Continuity of Care (42 CFR §438.208)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
services and supports (LTSS), or is a member of a priority population for intensive care coordination (ICC) as described in OAR 410-141-3870; or c. Sooner than the timeframes required if required by the member's health condition. ***The CCO shall maintain documentation on the health risk screening process, including subsequent attempts if the initial attempt to contact the member is unsuccessful.* *42 CFR § 438.208(b)(3)* *CCO Contract: Exhibit B Part 4 (1)* *OAR 410-141-3865 (3)(b)(A-C)*	• Samples of completed health risk screenings (one each) for the following: – Member not meeting criteria for screening in less than 90 days; – Member of prioritized population; – Member with special health care needs (SHCN); and – Member receiving LTSS. **Additional examples may be requested during the onsite.* • Timeliness tracking of outreach and health risk screening completions **Documents Submitted for Desk Review:** • LTSS.HEN.SNF.DP06018 Section 3 • Health.Risk.Assessment.Monitoring.DP13006 Section 3 • Health.Risk.Assessment.Screening.DP13007 section 3 • Cascade Health Alliance Member Handbook, pg. 27 Section "Health Risk Screening Tool (HRA)" • HRA Comp w in 90 Days Example • HRA Comp w in 30 Days Example • HRA Comp w in 30 Days pt 2 Example • Member.Experience.Health.Risk.Assessments.DP13012	
HSAG Findings: The CCO's Health Risk Assessment Screening Process stated that the CCO's customer service included the Health Risk Assessment (HRA) screening tool with the new member packet. Further, the policy stated that customer service contacted members to follow up		

Standard III—Coordination and Continuity of Care (42 CFR §438.208)		
Requirement	**Evidence as Submitted by the CCO**	**Score**

on the HRA completion, referred them to case management to assist with the HRA if needed, and that case management evaluated the HRA results weekly according to the ICCM evaluation tool process. However, the Health Risk Assessment Screening Process did not address the specific time frames for completing the initial HRA. The Member Experience Health Risk Assessment Process described capturing and recording HRAs. However, it did not include time frames for completion. The Health Risk Assessment Monitoring Process stated that the CCO's customer service audited 30 randomly selected member records at the end of each quarter. The record was reviewed for:

- Whether the HRA was sent in the new members' welcome packets.
- Whether the members returned the HRA in 30 days.
- Whether the HRA was not returned in 30 days, and if not, documentation of a follow-up call to the members at 30 days.

However, the document did not address/demonstrate:

- Specific time frame requirements for conducting the initial HRA.
- The CCO's process for ongoing HRA completion monitoring.
- The CCO's process for identifying members of prioritized populations that require HRA completions within 30 days versus 90 days.
- The CCO's monitoring of outreach attempts.

Although not submitted as evidence of element compliance, the CCO submitted the *Care Coordination* policy, stating that the CCO is to conduct an initial screening for all new members as quickly as the member's health condition required, but in no event more than 90 days of the effective enrollment date. If providers referred new members receiving Medicaid long-term (LT) care, long-term services and supports (LTSS), or members of a priority population for ICCM services, CHA conducted the initial screening within 30 days of the effective enrollment date. It also stated that members of prioritized populations were assessed for ICCM within 10 days of completing the HRA or sooner, if required by their health condition. It also stated that CHA documented subsequent attempts to contact the member if the initial attempt was unsuccessful. However, the policy did not describe outreach methods or the number of attempts.

The examples provided by the CCO illustrated the CCO's outreach to individual members when the HRA was received. However, the enrollment date was not included to demonstrate timeliness.

During the site visit, the CCO reported that its initial HRA also included components of the ICC assessment, and at least three outreach attempts were made to complete the initial HRA. The CCO was asked to describe how it identifies members needing the 30-day initial assessment, and the CCO referred to the Member Experience Health Risk Assessment, which illustrated a workflow for capturing and recording HRAs. However, it did not describe a process for identifying members needing the 30-day initial HRA. The CCO also was asked how it tracks timeliness, outreach, and successful outreach attempts. The CCO referred to its Health Risk Assessment Monitoring Process, which described a quarterly auditing process rather than ongoing monitoring to ensure initial screenings are completed on time. The CCO also reported it has

Standard III—Coordination and Continuity of Care (42 CFR §438.208)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
attempted to run queries to track HRA completions. However, the information is captured in notes that cannot be queried. The CCO reported that it is currently working on a system to capture this information. This requirement was *Partially Met*.		
Required Actions: The CCO must develop or revise an existing policy/workflow that describes the CCO's process for conducting the initial health screening, including the outreach method and number of attempts to reach members. The CCO must ensure its policies and processes align with federal requirements and the upcoming changes to the OARs, effective February 2024, and demonstrate implementation.		
4. The CCO implements procedures to share with participating medical providers, the State, CCOs, or other entities serving the member the results of its identification and assessment of that member's needs to prevent duplication of those activities. *42 CFR § 438.208(b)(4)* *Contract: Exhibit B Part 4 (2)(g)(3)* *OAR 410-141-3865(4)(c)*	**Suggested Documents:** • Care Coordination and/or Care Management policies and procedures • Sample documentation showing sharing of assessments with relevant entities involved in the member's care *HSAG will also use the results of the care coordination file review **Documents Submitted for Desk Review:** • Care.Coordination.PP06003 Page 3 Section 4.8 • BH.Care.Coordination.PP06003.03, (Section 4.4.2, 4.4.2.1-4.4.2.5) • Cascade Health Alliance Member Handbook (Section: Quick Guide, Care Coordination and Other Services, Paragraphs 1-3, page 30) • Care Coordination Services description for Members, CHA Website: Sections: Paragraph 2, sentence 2, page 1 https://www.cascadehealthalliance.com/for-members/member-benefits/care-coordination-services/ • Care Coordination Services CHA Website Example	☐ Met ☐ Partially Met ☒ Not Met

Standard III—Coordination and Continuity of Care (42 CFR §438.208)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	• https://www.cascadehealthalliance.com/for-members/member-benefits/care-coordination-services/ • RN CM and BH CM coordination Example • LTSS.MOU.2022 (Section: Domain 2, pg. 4-5) • Welcome to CM letter template (Paragraph 3, sentence 3.) • Description of Transition of Care for Members, CHA Website (Section 2) • https://www.cascadehealthalliance.com/for-members/transition-of-care/ • CEFP Care Management Meeting Tracking Example	
HSAG Findings: The CCO's *Care Coordination* policy stated that the "care plan" is to be communicated to all care team providers. The policy indicated that for transitional care coordination, including appropriate discharge planning for short- and long-term hospital and institutional stays, the care manager is to work with providers, community resources, and any applicable State agencies to ensure the needs of members were met. The policy did not describe the process implemented by the CCO to share with participating medical providers, the State, CCOs, or other entities serving members the "results of its identification and assessment of the members' needs" to prevent duplication of those activities. During the site visit, the CCO reported it is not currently sharing the HRA results. This requirement was *Not Met*.		
Required Actions: The CCO must develop and implement a formal process for sharing the results of its identification and assessment of all members' needs with participating medical providers, the State, CCOs, or other entities serving its members.		
Recommendations: HSAG recommends that the CCO incorporate its process within the *Care Coordination* policy rather than creating a new policy.		
5. The CCO implements procedures to ensure that each provider furnishing services to members maintains and shares, as appropriate, a member health record in accordance with professional standards. *42 CFR § 438.208(b)(5)*	**Suggested Documents:** • Care Coordination and/or Care Management policies and procedures • Policies guiding health record disclosure for care coordination	☒ Met ☐ Partially Met ☐ Not Met

Standard III—Coordination and Continuity of Care (42 CFR §438.208)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	• Health/dental record documentation requirements or policies • Provider Manual, Provider Agreement, or other provider messaging regarding documentation requirements • Sample provider chart reviews/audits • Committee meeting minutes demonstrating monitoring of member health records **Documents Submitted for Desk Review:** • Record.Keeping.PP02017 sect 3 & 5.2 • Care Coordination Policy and Procedure. Pdf pg. 3 Section 4.2, 4.13.2 • Authorization.PP06001 Sect 4.1, 4.2.1, 4.2.3, 4.4.1 • Cascade Health Alliance Provider Manual: Pg 16 "Annual Audits" section Pg. 28 "Protected Health Info (PHI)" Section Pg 29 Record-Keeping and Retention section;	
HSAG Findings: This requirement was *Met*.		
Required Actions: None.		
6. The CCO implements procedures to ensure that in the process of coordinating care, each member's privacy is protected in accordance with the privacy requirements in 45 CFR parts 160 and 164, subparts A and E (Health Insurance Portability and Accountability Act of 1996 [HIPAA]), to the extent that they are applicable. *42 CFR § 438.208(b)(6)*	**Suggested Documents:** • Care Coordination and/or Care Management policies and procedures • Privacy/HIPAA policies and procedures *HSAG will also use the results of the care coordination file review	☒ Met ☐ Partially Met ☐ Not Met

Standard III—Coordination and Continuity of Care (42 CFR §438.208)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
CCO Contract: Exhibit B Part 4 (1)(a)	**Documents Submitted for Desk Review:** • Confidentiality.PP02005 Binder • Electronic.Communication.PP11006 • Cascade Health Alliance Member Handbook: "Your Records Are Private" and Privacy Notice sections pages 58-62 • Cascade Health Alliance Provider Manual pg. 28 "Protected Health Info (PHI)" Section • Annual HIPAA Training: Healthicity 2022 The Basics of HIPAA Privacy, Security, and HITECH Training	
HSAG Findings: This requirement was *Met*.		
Required Actions: None.		
7. The CCO implements mechanisms to comprehensively assess each member identified by the State as needing LTSS or having special health care needs to identify any ongoing special conditions of the member that require a course of treatment or regular care monitoring. The assessment mechanisms must use appropriate providers or individuals meeting LTSS service coordination requirements of the State or CCO, as appropriate. The CCO must conduct the ICC assessment: a. Within 10 days of completion of the health risk screening, or sooner if required by their health condition for prioritized populations. b. Within 30 days of referral or completion of an initial health risk screening for members with	**Suggested Documents:** • Member onboarding policies and procedures • Care Coordination and/or Care Management policies and procedures addressing ICC assessment processes • Protocols used to determine needs of the member and how the health plan will meet those needs • Sample ICC assessment form/template • Sample completed ICC assessment (one each) for the following: – Member of prioritized population; – Member with SHCN; – Member receiving LTSS;	☐ Met ☒ Partially Met ☐ Not Met

Standard III—Coordination and Continuity of Care (42 CFR §438.208)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
special health care needs (SHCN), members receiving LTSS, members with needs or conditions that may indicate a need for ICC services, and those self-referred or referred by the member's representative or provider. *42 CFR §438.208(c)(2)* *CCO Contract: Exhibit B Part 4(2)(g)* *CCO Contract: Exhibit B Part 4 (9)(a* *OAR 410-141-3865 (3)(d)* *OAR 410-141-3870 (2),(5)*	– Member identified during the health risk screening with needs or conditions that may indicate a need for ICC services; and – Member referred by self, representative or provider. **Additional examples may be requested during the onsite.* • Sample screenshots, dashboards, or spreadsheets to show tracking to ensure the assessments are completed within the appropriate time frame **Documents Submitted for Desk Review:** • Cascade Health Alliance Member Handbook, pg. 32, 49 • Transition of Care Between CCOs PP10004 section 4.4.1 • Assessment.Tool.for.Developing.Care.Plan.DP06008 section 2.2 • ICC Identified During HRA Example.docx • ICC Self-Referral Example.docx • LTSS ICC Example.docx • Member.Experience.Health.Risk.Assessments.DP13012	
HSAG Findings: None of the documents submitted (i.e., *Transition of Care Between Coordinated Care Organizations* policy or Member Experiences Health Risk Assessment Process) addressed the 10- and 30-day time frame requirements for completing a comprehensive assessment for the identified populations.		

Standard III—Coordination and Continuity of Care (42 CFR §438.208)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
Although not submitted for this element, the *Care Coordination* policy included the 10-day ICC assessment for prioritized populations and stated that provider referrals are screened within one business day, urgent non-admission referrals are screened within one business day, and non-urgent referrals are screened within 14 days. However, the policy did not address the specific time frame requirements for: • Completion of the HRA for members with special health care needs (SHCN). • Members receiving LTSS. • Members with needs or conditions that may indicate a need for ICC services. • Members self-referred or referred by their representative. The *Intensive Care Coordination and Case* Management policy also did not address this requirement. During the site visit, the CCO reported that all members are assessed within 10 days and clarified that the reference to a screening in policies indicates an assessment. However, the *Care Coordination* policy stated that non-urgent referrals are screened/assessed within 14 days, which did not align with the information reported by the CCO. The CCO also reported that it also makes three attempts to reach members to complete the assessment. However, this was not included in the CCO's policies. In addition, as stated in Element 3, the CCO did not have a current process for monitoring completions. Of the 11 sample cases selected for file review, nine of the files indicated the CCO could not reach the member. One of the files reviewed during the site visit showed an assessment that was completed in 30 days. However, the CCO could not confirm whether this member was identified as a prioritized population, which would have required a 10-day assessment. This also did not align with the process reported by the CCO that indicated all members are assessed within 10 days. The other file reviewed during the site visit regarding a member who was in a Seattle hospital. Specifically, the case manager involved worked with the hospital to connect the member with the appropriate discharge resources. The file reviews of members who could not be contacted revealed that the CCO did not consistently make three outreach attempts to connect with the members. Note: The *Transition of Care Between Coordinated Care Organizations* policy has not been reviewed/approved since 10/22/2019. This requirement was *Partially Met*.		
Required Actions: The CCO must ensure its policies and processes align with federal requirements and the upcoming changes to the OARs, effective February 2024, and demonstrate implementation. The CCO must revise its relevant policies and implement a process to conduct a comprehensive assessment within the time frames specified by the State. The CCO must also implement mechanisms and demonstrate ongoing monitoring of outreach and assessment completions to ensure compliance with established time frames.		

Standard III—Coordination and Continuity of Care (42 CFR §438.208)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
Recommendations: HSAG also recommends that the CCO ensure the *Transition of Care Between Coordinated Care Organizations* policy is reviewed and dated in accordance with its internal process, outlined in the CCO Overview Form, which indicated that policies are reviewed annually. This recommendation applies to all elements that document a review of the previously mentioned policy.		
8. The CCO shall implement processes for documenting all of the ICC services provided and attempted to be provided to members and for creating and implementing ICC plans for members requiring ICC services. The CCO must produce a treatment or service plan meeting federal and State criteria (a) through (e) for members who require LTSS and produce a treatment or service plan meeting criteria (c) through (e) for members with special health care needs that are determined through assessment to need a course of treatment or regular care monitoring. The ICC plan or treatment plan must be: a. Developed by an individual meeting LTSS service coordination requirements with member participation, and in consultation with any providers caring for the member. b. Developed by a person trained in person-centered planning using a person-centered process and plan (as defined in 441.301(c)(1) and (2) for LTSS treatment or service plans). c. Approved by the CCO in a timely manner (if such approval is required by the CCO). d. Be developed in accordance with OHA quality assessment and performance improvement utilization review standards.	**Suggested Documents:** • Member onboarding policies and procedures • Care Coordination and/or Care Management policies and procedures • Sample care plans (one each) for the following: – Member receiving LTSS with care plan **developed** during the CY 2022 review period; – Member receiving LTSS with care plan **reviewed/revised** during the CY 2022 review period; – Member receiving ICC services with care plan **developed** during the CY 2022 review period; and – Member receiving ICC services with care plan **reviewed/revised** during the CY 2022 review period. **Additional examples may be requested during the onsite.* • Sample screenshots, dashboards, or spreadsheets to show tracking to ensure the reassessments are completed within the time frame *HSAG will also use the results of the care coordination file review	☐ Met ☒ Partially Met ☐ Not Met

Standard III—Coordination and Continuity of Care (42 CFR §438.208)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
e. Reviewed and revised upon reassessment of functional need, at least **every three months** for member's receiving ICC services and **every 12 months** for other members or when the member's circumstances or needs change significantly, or at the request of the member. *42 CFR §438.208(c)(3)* *Contract: Exhibit B Part 4 (2)(g)(1)* *OAR 410-141-3870 (15)*	**Documents Submitted for Desk Review:** • Assessment.Tool.for.Developing.Care.Plan.DP0600 8 section 3.3, 3.6, 3.7 • Intensive.Care.Coordination.Case.Management.PP0 6006, pg. 4, section 4.4.4.4 • Transition of Care Between CCOs PP1004 • Cascade Health Alliance Member Handbook: Pg 27 (Health Risk Screening Tool), Pg 30, (Care coordination and Other Services), Pg 32 (Getting Specialty Care, Pg 48 (Additional Information "Intensive Care Coordination") • ICC Care Plan EX 1 • ICC Care Plan EX 2 • LTSS Care Plan EX 1 • LTSS Care Plan EX 2 • ICC Self-Referral Example 1 • JD.RN Intensive Care Case Manager • JD.Behavioral Health Case Manager • ICC Care Plan reviewed.revised (see page 58)	
HSAG Findings: The *Care Coordination*, *Intensive Care Coordination*, and *Case Management* policies stated that the case manager contacts the member to create a care plan in collaboration with the member, family representative, and provider in the member's preferred language. Further, the policies require that the care plan be responsive to the member's cultural needs. The policy also included sharing the care plan with the care team members. Finally, neither the *Care Coordination* policy, the *Intensive Care Coordination and Case Management* policy, nor the care management clinical pathways addressed the requirement to review and revise the care plan: • Upon reassessment of functional needs at least every three months for members receiving ICC services.		

Standard III—Coordination and Continuity of Care (42 CFR §438.208)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
• Every 12 months for non-ICC members or when the member's circumstances or needs change significantly. • At the request of the member. While the CCO is responsible for coordinating services for LTSS members, LTSS-specific care plans are developed by the Area Agencies on Aging/Aging and People with Disabilities (APD) through a Memorandum of Understanding with the CCO. Therefore, components (a) and (b) of this element are not applicable. The CCO's Assessment Tools for Developing Care Plan Process stated that care plans are created for all members with SHCN. This includes, but is not limited to, individuals who have high health care needs, multiple chronic conditions, mental illness or substance use disorders, and functional disabilities, or live with health or social conditions that place them at risk of developing functional disabilities or are a member of the prioritized populations. However, the process did not include LTSS members or revision/reassessment requirements. The two files that were able to be reviewed during the site visit demonstrated appropriate care plan development and updates. In addition, sample LTSS cases submitted with pre-onsite documentation also demonstrated an assessment within 30 days of enrollment, appropriate care plan development, and updates in the required 90-day time frame. This requirement was *Partially Met*.		
Required Actions: The CCO must revise its relevant policies and process documents to include the CCO's process for reviewing and revising the care plan. The CCO must ensure its policies and processes align with federal requirements and the upcoming changes to the OARs, effective February 2024, and demonstrate implementation.		
Recommendations: HSAG recommends that the CCO implement monitoring mechanisms to ensure compliance with established care plan review and reassessment requirements.		
9. For members with special health care needs determined through an assessment by appropriate health care professionals to need a course of treatment or regular care monitoring, the CCO must have a mechanism in place to allow members to directly access a specialist (for example, through a standing referral or an approved number of visits) as appropriate for the member's condition and identified needs. *42 CFR § 438.208(c)(4)* *Contract: Exhibit B Part 4 (2)(g)(2)* *OAR 410-141-3870 (19)*	**Suggested Documents:** • Policies and procedures on direct access for SHCN members • Materials informing SHCN members about direct access to specialists and the approval process • Samples documentation showing members being granted direct access **Documents Submitted for Desk Review:** • Specialty.Care.Referral.PP12002 section 4.7 and 4.9	☒ Met ☐ Partially Met ☐ Not Met

Standard III—Coordination and Continuity of Care (42 CFR §438.208)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	• Access.to.Care.PP06002 Sec. 4.10.1.2 • 12222021-auth-grid-final COPY • Cascade Health Alliance Member Handbook pg. 32 "Getting Specialty Care" • Authorization.PP06001 Sec. 4.1.1 • BH Auth Grid • Auth-Grid-Final • No Auth Required BH Example • No Auth Required Dialysis Example • No Auth Required Diabetic Eye Example 1 • No Auth Required Diabetic Eye Example 2	
HSAG Findings: The *Specialty Care Referral* policy referred to the Prior Authorization Grid. The authorization grid identified that ICCM members did not need prior authorization for an initial evaluation and two follow-up visits with area specialists. The member handbook communicated that members enrolled in ICC, receiving LTSS, or with SHCN did not need prior authorization for specialists, medically appropriate care, or behavioral health services to treat the member's identified needs. During the site visit, the CCO reported that all members are permitted to refer themselves to any in-network specialist for an initial evaluation and two follow-up visits. The CCO reported that case managers would work with members to receive ongoing access to specialists appropriate for the members' conditions and identified needs. Following the site visit, the CCO submitted its Condition Management Care Pathway, which included providing referrals to specialty providers and resources as appropriate. The CCO submitted example cases demonstrating that authorizations were not needed for certain services. However, it was not evident in the example cases that all were for members identified as members with SHCN or were ICC members. This requirement was *Met*.		
Required Actions: None.		
Recommendations: HSAG recommends that the CCO update its *Care Coordination* policy to include the CCO's case management process to arrange referrals for members with SHCN beyond the initial and two follow-up visits.		

Results for Standard III—Coordination and Continuity of Care							
Total	Met	=	5	X	1.0	=	5.0
	Partially Met	=	3	X	0.5	=	1.5
	Not Met	=	1	X	0.0	=	0.0
Total Applicable		=	9	**Total Score**		=	6.5

Total Score ÷ Total Applicable	=	**72.2%**

Standard IV—Coverage and Authorization of Services

Standard IV—Coverage and Authorization of Services (42 CFR §438.210)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
1. The CCO must: a. Specify the amount, duration, and scope of each service that the CCO is required to offer. b. Ensure that the services defined in the contract are sufficient in amount, duration, or scope to reasonably achieve the purpose for which the services are furnished. i. Services may not be less than the amount, duration, and scope for the same services delivered to FFS Medicaid members. ii. Services for members under 21 must meet requirements set forth in subpart B of part 42 CFR §440.40(b) and subpart b of 42 CFR §441 (EPSDT services). *42 CFR § 438.210(a)(2);(3)(i)* *Contract: Exhibit B Part 2(2)(b)* *OAR 410-141-3835(6)*	**Suggested Documents:** • Coverage and authorization policies and procedures • Utilization management (UM) plan/utilization review (UR) policies and procedures • Service Authorization Handbook • Plan documents outlining the services defined in the contract • Member materials, such as the member handbook and benefits grid **Documents Submitted for Desk Review:** • Coverage and Authorization of Services Policy and Procedure, 3.1-3.4, 3.6 • URPlanPP06005 section 4.5 • Cascade Health Alliance member Handbook, page 14-23, page (uploaded in Standard III) • Cascade Health Alliance Provider Manual, Benefits, page 22-24 (uploaded in Standard III)	☒ Met ☐ Partially Met ☐ Not Met
HSAG Findings: The *Coverage and Authorization of Services* policy addressed the specific requirements of this element. The Utilization Review Plan detailed that "utilization determinations consider anticipated longer-term medical, social, and quality of life issues in the utilization review process and includes implications for independent living, support for the least restrictive residential setting for the member, and skills acquisition for the member to perform activities of daily living." The amount, duration, and scope of services were presented within the member handbook. An overview of benefits, with links for more details, was included in the provider manual. The CCO did not have a formal policy or procedure for furnishing Early and Periodic Screening, Diagnostic, and Treatment (EPSDT), although the *Coverage and Authorization of Services* policy stated the CCO would provide covered services for members under the age of 21, set forth in subpart B of 42 CFR §441. The		

Standard IV—Coverage and Authorization of Services (42 CFR §438.210)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
CCO also submitted its *Health Promotion and Prevention* policy, which stated that the CCO expects providers to actively promote all health screenings recommended by Bright Futures. The policy's Procedure section indicated the CCO "will establish" processes and workflows to ensure recommended health screenings are performed appropriately for each member and the Quality Management Department "will establish" an annual plan for health promotion and prevention activities as part of its annual strategic planning process. During the site visit, the CCO explained that their process for approving EPSDT services is based solely on medical necessity and appropriateness, not the prioritized list. The CCO also confirmed that prior authorization is not required for any EPSDT preventative screenings, and information related to EPSDT services was communicated to members via the member handbook. Note: The *Coverage and Authorization of Services* policy has not been reviewed/approved since 07/31/2019. The Utilization Review Plan has not been reviewed/approved since 09/21/2018. This requirement was *Met*.		
Required Actions: None.		
Recommendations: HSAG recommends that the CCO formally develop its processes and workflows for furnishing EPSDT services in accordance with subpart B of part 42 CFR §440.40(b) and subpart b of 42 CFR §441. This recommended action will ensure compliance with the next CMR audit of the Coverage and Authorization of Services standard. HSAG also recommends that the CCO ensure the *Coverage and Authorization of Services* policy and the Utilization Review Plan are reviewed and dated in accordance with its internal process, outlined within the CCO Overview Form, which indicated policies are reviewed annually. This recommendation applies to all elements that document a review of the previously mentioned policies.		
2. The CCO does not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the member. *42 CFR § 438.210(a)(3)(ii)* *Contract: Exhibit B Part 2(2)(a-b)* *OAR 410-141-3835(7)*	**Suggested Documents:** • Coverage and authorization policies and procedures • Service Authorization Handbook • UM plan/UR policies and procedures • Plan documents outlining process for determining service denials • Coverage guidelines/criteria **Documents Submitted for Desk Review:** • Coverage and Authorization of Services Policy and Procedure 06021, 3.3, 3.6	☒ Met ☐ Partially Met ☐ Not Met

Standard IV—Coverage and Authorization of Services (42 CFR §438.210)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	• Cascade Health Alliance member Handbook, page 58 (uploaded in Standard III)	
HSAG Findings: This requirement was *Met*.		
Required Actions: None.		
3. The CCO may place appropriate limits on services-- a. On the basis of criteria applied under the State plan (such as medical necessity). b. For the purpose of utilization control, provided that: i. The services furnished can reasonably achieve their purpose. ii. The services supporting individuals with ongoing or chronic conditions or who require long-term services and supports are authorized in a manner that reflects the member's ongoing need for such services and supports. iii. Family planning services are provided in a manner that enables the member to choose the method of family planning. *42 CFR § 438.210(a)(4)* *Contract: Exhibit B Part 2(3)(b)(3)* *OAR 410-141-3835(9)*	**Suggested Documents:** • Coverage and authorization policies and procedures • Service Authorization Handbook • UM plan/UR policies and procedures • Plan documents outlining processes for determining quantitative and non-quantitative service limits • Coverage guidelines/criteria, including pharmacy • Member materials, such as member handbook **Documents Submitted for Desk Review:** • Coverage and Authorization of Services Policy and Procedure 06021, 3.2 (3b.i), 4.1 (for 3a) 3.8 (for 3b.ii) • Cascade Health Alliance Member Handbook pg. 15-25; Pg. 40 Services Not Covered; Pg 38, Family Planning and Other Services; Pg. 54 Maternity CM	☒ Met ☐ Partially Met ☐ Not Met

Standard IV—Coverage and Authorization of Services (42 CFR §438.210)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	• Cascade Health Alliance Provider Manual: Pg. 2 OHA Web Resources- Prioritized List of Health Services Pg. 24-25 Benefits, Pg. 26 Services Not Covered • URPlanPP06005 section 4.5	
HSAG Findings: This requirement was *Met*.		
Required Actions: None.		
4. The CCO specifies what constitutes medically necessary covered services and administers the services in a manner that: a. Is no more restrictive than that used in the State Medicaid program, including quantitative and non-quantitative limits (as indicated in other State policies, procedures and administrative rules). b. Takes into account and addresses the following: i. The prevention, diagnosis, and treatment of a member's disease, condition, and/or disorder that results in health impairments and/or disability. ii. The ability for a member to achieve age-appropriate growth and development. iii. The ability for a member to attain, maintain, or regain functional capacity. iv. The opportunity for a member receiving long-term services and supports to have access to the benefits of community living, to achieve person centered goals, and live and work in the setting of their choice.	**Suggested Documents:** • Coverage and authorization policies and procedures • Service Authorization Handbook • UM plan/UR policies and procedures • Medical necessity criteria utilized (e.g., InterQual, MCG) **Documents Submitted for Desk Review:** • Coverage and Authorization of.Services.PP06021.pdf- pages 1-2 Section 3.4.1-3.4.1.3 • Medical Auth Grid (uploaded in Standard III) • BH Auth Grid 58 (uploaded in Standard III) • URPlanPP06005 section 4.5	☒ Met ☐ Partially Met ☐ Not Met

Standard IV—Coverage and Authorization of Services (42 CFR §438.210)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
42 CFR § 438.210(a)(5) *Contract: Exhibit B Part 2(2)(b)*		
HSAG Findings: This requirement was *Met*.		
Required Actions: None.		
5. The CCO and its subcontractors have in place and follow written policies and procedures that address the processing of requests for initial and continuing authorization of services. a. The CCO/subcontractor's policies and procedures must <u>also</u> comply with prior authorization requirements outlined in Contract: Exhibit B Part 2(3)(b). *42 CFR § 438.210(b)(1)* *Contract: Exhibit B Part 2(3)(a)* *OAR 410-141-3835(10)(f)(C)*	**Suggested Documents:** • UM plan/UR policies and procedures outlining procedures Coverage and authorization policies and procedures • Service and Authorization Handbook • Audit results from delegation oversight of policies and procedures **CCO should be prepared to provide copies of delegated entities' policies and procedures upon request* **Documents Submitted for Desk Review:** • URPlanPP06005 • Coverage and Authorization of.Services.PP06021 • Auth Flow PP06001.01 • Turnaround.Time.PP06014 • Cascade Health Alliance Provider Manual, page 31, Violations and Consequences • 1.August 22 URC Minutes, Agenda, P&R Dental IRR, • 2.November 22 URC Minutes, Agenda, P&R Dental IRR • IRR.CHA.UR Audit 20222 Q4 FINAL.pdf	☒ Met ☐ Partially Met ☐ Not Met

Standard IV—Coverage and Authorization of Services (42 CFR §438.210)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	• IRR.PandR2022Q4 Report Cascade Health 1 of 3.pdf • IRR.PandR2022Q4 Report Cascade Health 2 of 3.pdf • IRR.PandR2022Q4 Report Cascade Health 3 of 3.pdf • 9.9.22 KBBH Onsite • 12.30.22 KOD Onsite Audit • 8.19.22 LCS Onsite	
HSAG Findings: This requirement was *Met*.		
Required Actions: None.		
6. The CCO has and follows written policies and procedures that include mechanisms to ensure consistent application of review criteria for authorization decisions. *42 CFR §438.210(b)(2)(i)* *Contract: Exhibit B Part 2(3)(b)(1)* *OAR 410-141-3835(10)(f)*	**Suggested Documents:** • UM plan/UR policies and procedures • Coverage and authorization policies and procedures • Coverage guidelines/criteria • Service authorization handbook • Results of inter-rater reliability (IRR) activities • Committee meeting minutes where IRR results are reviewed **Documents Submitted for Desk Review:** • Coverage.and.Authorization.of.Services.PP0 6021, 4.1, 5.1 • Auth Grid • BH Auth Grid	☒ Met ☐ Partially Met ☐ Not Met

Standard IV—Coverage and Authorization of Services (42 CFR §438.210)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	• Dental Auth Grid • 1.August 22 URC Minutes, Agenda, P&R Dental IRR • 2.November 22 URC Minutes, Agenda, P&R Dental IRR • IRR.CHA.UR Audit 20222 Q4 FINAL.pdf • IRR.PandR2022Q4 Report Cascade Health 1 of 3.pdf • IRR.PandR2022Q4 Report Cascade Health 2 of 3.pdf • IRR.PandR2022Q4 Report Cascade Health 3 of 3.pdf	

HSAG Findings: The *Coverage and Authorization of Services* policy outlined how the CCO will ensure that review criteria are consistently applied to:

- Authorization decisions by hiring qualified review staff.
- Review of staff training.
- Documentation of policies, procedures, and workflows.
- Regular use of decision support tools.
- Regular reviewer inter-rater reliability (IRR) testing.

However, the policy did not include the frequency of IRR testing or the minimum threshold.

The Authorization Request Fax/Portal Workflow, submitted for a different element, detailed the process for reviewing, approving, or denying service requests. The Utilization Review Plan, submitted for a different element, demonstrated that the CCO has policies and procedures that address review criteria for authorization decisions. The Prior Authorization Grid, BH Authorization Grid, and Dental Authorization Grid demonstrated the CCO's checklist for authorized services. CHA Utilization Review Committee Minutes (August and November) demonstrated that the CCO reviewed dental IRR reviews. However, the minutes did not reflect overall results or threshold standards. The minutes did not include a review of IRR testing for physical and behavioral health services. The CHA Utilization Review IRR Audit Q4 demonstrated that the CCO conducted IRR reviews of 24 combined physical/behavioral health, four dental, and two pharmacy claims.

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Requirement	**Evidence as Submitted by the CCO**	**Score**
During the site visit, the CCO described its IRR process, overseen by the CCO's medical director, who conducted a peer review of each case, and all reviewers were represented in the activity. The CCO reported that it does not have a defined threshold or level of acceptance for the IRR review, but rather, the CCO provides retraining when trends are identified. This requirement was *Met*.		
Required Actions: None.		
Recommendations: HSAG recommends reviewing IRR results for patterns to assess whether there is a personal reviewer issue or systemic process issue. HSAG further recommends that the CCO define a level of agreement/threshold that triggers reviewer retraining and removal from rotation if performance does not improve following retraining to ensure consistent application of review criteria. HSAG also recommends that the CCO ensure all quarterly IRR audit results are included in Utilization Review Committee minutes, including results compared to established thresholds and any retraining completed as a result of IRR testing.		
7. The CCO has and follows written policies and procedures to consult with the requesting provider for medical services when appropriate. *42 CFR §438.210(b)(2)(ii)* *Contract: Exhibit B Part 2(3)(a)* *OAR 410-141-3835(10)(f)(A)*	**Suggested Documents:** • UM plan/UR policies and procedures Coverage and authorization policies and procedures • Service Authorization Handbook • Three examples of peer-to-peer consults **Documents Submitted for Desk Review:** • Coverage and Authorization of Services Policy and Procedure 06001, 3.7 • Auth Grid • BH Auth Grid • Dental Auth Grid • 14.Reconsiderations.PP02014 • 3.Adams Written Reconsideration • 4.Walch Written Reconsideration to URC, • 5.Gailey Written Reconsideration • 6.Shoudy Peer to Peer Reconsideration • 7.Ordoff Peer to Peer Reconsideration,	☐ Met ☒ Partially Met ☐ Not Met

Standard IV—Coverage and Authorization of Services (42 CFR §438.210)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	• 8.Montgomery Peer to Peer Reconsideration	
HSAG Findings: The *Coverage and Authorization of Services* policy stated that reviewers consult with the requesting provider for medical services when appropriate. The *Reconsiderations* policy required the CCO to accept peer-to-peer reconsiderations and complete documentation of the conversation with the provider that requested adverse benefit determination reconsideration on a member's behalf. The policy also stated that all reconsideration requests are treated as provider appeals and, prior to submitting the request, the provider will need to obtain permission from the member. However, the policy included a 30-day limit for the provider to request a reconsideration and stated that the CCO would resolve and notify the provider approximately 30 calendar days from receiving a complete reconsideration request. This language does not align with the appeal time frame of 16 days. The policy also stated that if reconsideration results in an upheld denial, the member must also request an appeal to obtain his/her right to a contested case hearing. However, there is only one level of appeal. This information also was communicated in the provider manual. Interviews during the site visit as well as examples of peer-to-peer reconsiderations submitted for review confirmed that the CCO used the reconsideration/peer-to-peer consultation process after a notice of adverse benefit determination (NOABD) had been issued. The CCO also reversed denial decisions based upon information discussed/received rather than as a means to inform the requesting provider of the denial reason and assist the provider in deciding to appeal the decision. Note: The *Reconsiderations* policy has not been reviewed/approved since 10/5/2020. This requirement was *Partially Met*.		
Required Actions: The CCO must ensure its consulting process with the requesting provider occurs before the authorization decision and issuance of the NOABD when the CCO believes additional information is required to decide. The CCO also must ensure peer-to-peer consultations are conducted to inform requesting providers of its adverse benefit determination reasoning. Moreover, the CCO must provide information needed by the requesting provider to determine whether to appeal the decision. In addition, the CCO must ensure its process does not include reversing adverse benefit determinations and aligns with State and federal regulatory requirements that require the CCO to treat provider requests for redetermination as provider-initiated appeals. Finally, the CCO must update its provider manual and relevant policies to reflect a process for consulting with the requesting provider prior to making an authorization decision and remove all language pertaining to a reconsideration process.		
Recommendations: HSAG recommends that the CCO ensure the *Reconsiderations* policy is reviewed and dated in accordance with its internal process, outlined in the CCO Overview Form, which indicated that policies are reviewed annually. This recommendation applies to all elements that document a review of this policy.		

Standard IV—Coverage and Authorization of Services (42 CFR §438.210)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
8. The CCO ensures that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by an individual who has appropriate expertise in treating the member's medical, behavioral health, oral health, or long-term services and supports needs. *42 CFR §438.210(b)(3)* *Contract: Exhibit B Part 2(3)(b)(2)*	**Suggested Documents:** • Coverage and authorization policies and procedures • Service Authorization Handbook • UM plan/UR policies and procedures • Policies and procedures outlining service authorization denials • Job descriptions/minimum qualifications for UM decision makers *HSAG will also use the results of the service authorization denial file review **Documents Submitted for Desk Review:** • Coverage and Authorization of Services Policy and Procedure, 3.8 • Specialty Care ReferralPP12002, 4.7, 4.8 (uploaded to Standard III) • JD Physician Clinical Reviewer.pdf • IRR.PandR2022Q4 Report Cascade Health 1 of 3.pdf • IRR.PandR2022Q4 Report Cascade Health 2 of 3.pdf • IRR.PandR2022Q4 Report Cascade Health 3 of 3.pdf • Dental Denial by P and R Example • Surgery Denial by MD Example	☒ Met ☐ Partially Met ☐ Not Met

Standard IV—Coverage and Authorization of Services (42 CFR §438.210)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
HSAG Findings: The *Coverage and Authorization of Services* policy addressed the specific requirements of this element. The *Specialty Care Referral* policy indicated that the medical director evaluates authorization requests, and makes determinations based on OHA's prioritized list and accompanying guideline notes. During the site visit, the CCO described its process for making prior authorization coverage decisions that aligned with its policies. File reviews revealed that the prior authorization decision-maker had the appropriate clinical expertise for all sample cases reviewed. Note: The *Specialty Care Referral* policy has not been reviewed/approved since 10/01/2018. This requirement was *Met*.		
Required Actions: None.		
Recommendations: HSAG also recommends that the CCO ensure the *Specialty Care Referral* policy is reviewed and dated in accordance with its internal process, outlined within the CCO Overview Form, which indicated that policies are reviewed annually. This recommendation applies to all elements that document a review of this policy.		
9. The CCO has and follows written policies and procedures that include the following time frames for making standard and expedited authorization decisions: a. For standard authorization decisions—as expeditiously as the member's physical health, oral, or behavioral health condition requires, but no later than **14 calendar days** from the receipt of the request for service authorization.**The CCO makes three attempts using two methods to obtain the necessary information during the 14-day period.* b. If the provider indicates, or the CCO determines, that following the standard time frames could seriously jeopardize the member's life or health, or ability to attain, maintain, or regain maximum function, the CCO makes an expedited authorization determination and provides notice as expeditiously as the member's condition requires and no later than **72 hours** after receipt of the request for service.	**Suggested Documents:** • Coverage and authorization policies and procedures • UM plan/UR policies and procedures • Service Authorization Handbook • Service authorization turn-around-time tracking • Extension notice template • Three examples of an extensions notice and corresponding determination notice *HSAG will also use the results of the service authorization file review **Documents Submitted for Desk Review:** • Care.Coordination.PP06003 section 4.3.3 (a) (uploaded to Standard III) • Cascade Health Alliance Provider manual	☐ Met ☒ Partially Met ☐ Not Met

Standard IV—Coverage and Authorization of Services (42 CFR §438.210)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
c. The time frame for making standard or expedited authorization decisions may be extended by up to **14 additional calendar days** if: i. The member or the provider requests an extension, or ii. The CCO justifies (to the State upon request) a need for additional information and how the extension is in the member's interest. iii. If the CCO extends the time frame for standard or expedited authorization decisions, it must: – Give the member written notice of the reason for the extension (no later than the date the authorization time frame expires). – Inform the member of the right to file a grievance if he or she disagrees with that decision. – Issue and carry out its determination as expeditiously as the member's health condition requires and no later than the date the extension expires. *42 CFR §438.210(d)(1-2)* *42 CFR §438.404(c)(4)* *Contract: Exhibit B Part 2(3)(b)(11);(12)* *OAR 410-141-3835(10)(a)(A)* *OAR 410-141-3835(10)(a)(B)(i)* *OAR 410-141-3835(10)(g)(A)*	Pg 33, When does CHA respond to a submitted Appeal Pg 36 NOABD Timelines Pg 40 Utilization Review Pg 43 Urgent Authorizations • Turnaround.Time.PP06014 pg 1 & 2 4.2, 4.3, 4.4, 4.5 • Authorization.PP06001 (uploaded to Standard III) • Specialty.Care.Referral.PP12002 4.9 (Uploaded to Standard III)	
HSAG Findings: The *Turnaround Time* policy outlined the CCO's processes and standards for timely service authorizations. However, the policy did not specify that the member will be informed in writing if a 14-day extension is enacted. Neither did the policy state that the member has the right to file a grievance if he/she disagrees with the extension and failed to require the CCO to use "two methods" during its three		

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Requirement	**Evidence as Submitted by the CCO**	**Score**
attempts to obtain the necessary information during the 14 days. The CCO was also unable to demonstrate making three attempts to obtain information within file reviews. In addition, the policy included the provider as an individual permitted to request an extension of a standard authorization, but not expedited. The *Authorization* policy included standard and expedited request time frames and the 14-day extension. However, the policy did not include making decisions as expeditiously as the member's physical, oral, or behavioral health conditions require for standard or expedited decisions or circumstances that would warrant an expedited request (i.e., the provider indicates, or the CCO determines, that following the standard time frames could seriously jeopardize the member's life or health, or ability to attain, maintain, or regain maximum function). In addition, the policy stated that the CCO would cancel authorizations for various reasons, including but not limited to, the provider requesting a cancellation, missing information after three attempts using two different methods, invalid requests, etc. This practice is not in alignment with regulatory requirements. It was unclear how this policy was distinguished from the *Turnaround Time* policy and procedure, and appears to have duplicative and sometimes conflicting information. The CCO also submitted its *Specialty Care Referral* policy, which included the provision specifying that the CCO inform providers and members of authorization determinations within 14 days. However, it did not address the additional time requirements in this element. During the site visit, the CCO demonstrated tracking prior authorization decision timeliness through daily Utilization Review Team huddles occurring each morning and afternoon. Note: The *Authorization* policy has not been reviewed since 8/10/20, and the *Turnaround Time* policy has not been reviewed since 1/6/20. This requirement was *Partially Met*.		
Required Actions: The CCO must revise its *Turnaround Time*, *Authorization*, and *Specialty Care Referral* policies regarding service authorizations to reflect all requirements specified in this element. The CCO also must demonstrate a process to ensure three attempts via two different methods are used to obtain additional information. Further, the CCO must demonstrate that: • Those attempts are documented in the authorization file. • Members are informed in writing when an authorization time frame is extended. • Members are informed of their right to grieve any extensions.		
Recommendations: HSAG recommends that the CCO streamline the multiple policies that appear to address the same processes (e.g., *Turnaround Time* and *Authorization* policies). HSAG also recommends that the CCO ensure the *Authorization* and *Turnaround Time* policies are reviewed and dated in accordance with its internal process, outlined in the CCO Overview Form, which indicated that policies are reviewed annually. This recommendation applies to all elements that document a review of these policies.		

Standard IV—Coverage and Authorization of Services (42 CFR §438.210)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
10. The CCO has and follows written policies and procedures that include processes for notifying the requesting provider and giving the member written notice of any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. (notice to the provider need not be in writing). a. If the CCO denies a request for a service authorization or authorizes a service in an amount, duration or scope less than requested, the CCO mails the notice of adverse benefit determination (NOABD) within the following time frames: i. For standard service authorization decisions that deny or limit services, within 14 calendar days of the request for authorization. ii. For expedited service authorization decisions, within 72 hours of the request for authorization. iii. For service authorization decisions not reached within the required time frames specified in §438.210(d), on the date these time frames expire. *42 CFR §438.210(c);(d)* *Contract: Exhibit B Part 2(3)(b)(11);(17);(18)* *OAR 410-141-3835(10)(d);(e)*	**Suggested Documents:** • Coverage and authorization policies and procedures • UM plan/UR policies and procedures • Service Authorization Handbook • NOABD turn-around-time tracking • NOABD letter template • Three examples of NOABD sent to a member for service authorizations not reached within the required timeframes *HSAG will also use the results of the service authorization and denial file review **Documents Submitted for Desk Review:** • Turnaround.Time.PP06014 Sections 4.2, 4.4, 4.5, 4.6 • Authorization.PP06001 section 3.2 • Cascade Health Alliance Provider manual Pg 36 NOABD Timelines Pg 43 Urgent Authorizations • NOABD Workflow-Desktop.Process • NOABD Member Letter Template • 0.Grievance and Appeal System Binder 2022; Pg 31 sections 2.1, 2.2.1, 2.2.2, Pg 36 sections 2.10, 2.10.1	☒ Met ☐ Partially Met ☐ Not Met

Standard IV—Coverage and Authorization of Services (42 CFR §438.210)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	• 15.Denials.thru.20221231 (highlighted Avg Days to Process). • 7.Q3 2022 Grievance and Appeals Exhibit I, NOABD Log tab & NOABD-Appeal Summary tab relate any NOABDs issued beyond 14 days.	
HSAG Findings: The *Grievance and Appeal System Binder*, *Appendix 4–Notice of Adverse Benefit Determination Application* procedure addressed the requirements of this element. The *Turnaround Time* and *Authorization* policies did not include providing notice for authorized decisions not reached within the time frames specified in §438.210(d), on the date these time frames expire. However, this information was included within the appropriate relevant policy. The NOABD Letter Workflow Process established the standard processes and time frames for staff to follow to complete NOABD letters and demonstrated Essette system screen shots used by the CCO to process service authorization requests. The workflow included a step that serves as CHA attestation that the NOABD letters were completed timely. It also demonstrated that an NOABD compliance report can be generated. During the site visit, the CCO presented multiple reporting mechanisms for tracking NOABDs' timeliness. File reviews of the CCO, both standard and expedited requests, revealed timely NOABDs. This requirement was *Met.*		
Required Actions: None.		
Recommendations: Although this element is scored as Met, HSAG recommends the CCO either revise its *Turnaround Time* and *Authorization* policies to include all requirements specified in this element or streamline its policy and procedure structure to eliminate duplication and/or conflicting information in policies.		
11. Policies and procedures for processing authorization requests specify time frames for the following: a. Date and time stamping prior authorization requests when received. b. Determining within a specific number of days from receipt whether a prior authorization request is valid or non-valid.	**Suggested Documents:** • Coverage and authorization policies and procedures • UM plan/UR policies and procedures **Documents Submitted for Desk Review:** • Turnaround.Time.PP06014 (Sections 1.1, 4.1-4.4, 4.6, 4.8) • AuthorizationPP06001 sections 3.2, 4.9-4.9.6.1	☒ Met ☐ Partially Met ☐ Not Met

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Requirement	**Evidence as Submitted by the CCO**	**Score**
c. The specific number of days allowed for follow-up on pended prior authorization requests to obtain additional information. d. The specific number of days following receipt of the additional information that an approval or denial shall be issued. e. Providing services after office hours and on weekends that require prior authorization. *42 CFR §438.210(b)(1)* *OAR 410-141-3835(10)(f)(C)*	• Coverage.and.Authorization.of.Services.PP0 6021 (Section 3.1) • Outpatient.Drug.Authorization.Decision.PP0 8002 • CHA UR Holiday Weekend Coverage • Cascade Health Alliance Provider manual Pg 36 NOABD Timelines Pg 40 Utilization Review Pg 42 Authorization Modifications Pg 43 Urgent Authorizations	
HSAG Findings: The *Turnaround Time* addressed the specific requirements of this element. HSAG notes that the CCO did not identify specific days allowed for follow-up on pended authorizations and for making the decision upon receipt of additional information. Still, the CCO's policy clearly indicated it would make use of the entire 14-day time period to determine validity, request additional information, and make the determination. The policy did not specifically address after-hours and weekend services for prior authorization. However, the policy stated, "If appropriately supported, urgent requests received after hours, or on weekends, will be retroactively authorized." In addition, the Utilization Review Holiday Weekend Coverage screenshot demonstrated that the CCO has staffing in place during holiday weekends. Its stated goal is to ensure compliance with completing a review of urgent authorization requests within 72 hours. Although *the Coverage and Authorization of Services* policy and procedure did not address the time stamping and specific number of days allowed for follow-up, it did document that the CCO will authorize covered services in accordance with 42 CFR §438.210 and the OAR contract. The *Authorization* policy and procedure did not include the requirements of this element. However, this information was included in an appropriate relevant policy. The *Outpatient Drug Authorization Decision* policy documented the CCO's process for authorizing outpatient drug requests within 24 hours. The provider manual informed providers of the specific number of days to process service authorization requests as required in this element. The NOABD Letter Workflow Process, submitted for another element, established the standard processes and time frames for staff to follow to complete NOABD letters and demonstrated Essette system screen shots used by the CCO to process service authorization requests, including the date received (timestamp). This requirement was *Met*.		
Required Actions: None.		

Standard IV—Coverage and Authorization of Services (42 CFR §438.210)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
Recommendations: Although this element is scored as *Met*, HSAG recommends the CCO either revise its *Authorization* policy to include all requirements specified in this element or streamline its policy and procedure structure to eliminate duplication and/or conflicting information in policies.		
12. If the CCO denies payment for a service, in whole, or in part, the CCO mails the notice of adverse benefit determination at the time of any denial affecting the claim. **A payment denied solely because the claim does not meet the definition of a "clean claim" defined in 42 CFR §447.45(b) is not an adverse benefit determination.* *42 CFR §438.404(c)* *Contract: Exhibit I(3)(b)(2)* *OAR 410-141-3875(1)(C)*	**Suggested Documents:** • Claims denial of payment policies and procedures • Plan documents outlining requirement to provide NOABD at the time of any denial affecting the claim • Workflow for payment denial on a claim to trigger NOABD • Three examples of NOABD sent to a member for the denial of payment on a claim • NOABD turn-around-time tracking • Denial of claims payment NOABD letter template *HSAG will also use the results of the service authorization file review **Documents Submitted for Desk Review:** • NOABD Packet Template Approved.pdf • 1.2022 Claims NOABD approved Feb 2023 • 1a. 2022 Claims NOABD Attachments approved Jan 2023 • 0.Grievance and Appeal System Binder 2022; Pg 31. Section 2.2.3, Pg 32 Section 2.2.3.1.1	☐ Met ☒ Partially Met ☐ Not Met

Standard IV—Coverage and Authorization of Services (42 CFR §438.210)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
HSAG Findings: The *Grievance and Appeal System Binder*, *Appendix 4–Notice of Adverse Benefit Determination Application* procedure stated the CCO will mail an NOABD at the time of any adverse benefit determination that effects the claim for denial of payment, excluding claims that do not meet the definition of a clean claim. The Claims NOABD Template demonstrated that the CCO has a template for the notification a member receives when a claim is denied. During the site visit, the CCO reported that its policy and procedure for processing claims denials is being finalized, and the CCO just began mailing claim NOABDs this month (July 2023). The CCO described its process for identifying clean claims and issuing claims NOABDs. However, the CCO reported it is still finalizing system configuration updates. The CCO also reported that its plan for monitoring will include a comparison of claims against notices sent. This requirement was *Partially Met*.		
Required Actions: The CCO must fully implement its process for sending NOABDs for claim denials and demonstrate that monitoring mechanisms are in place to ensure its processes are effective.		
13. If the CCO proposes to reduce, suspend, or terminate a previously authorized Medicaid-covered service, the CCO gives advance notice (notice of adverse benefit determination) at least ten (10) days before the proposed effective date **except** when: a. The CCO gives notice on or before the date of action if: i. The agency has factual information confirming the death of a member. ii. The agency receives a clear written statement signed by the member that he/she no longer wishes services or gives information that requires termination or reduction of services and indicates that he/she understands that this must be the result of supplying that information. iii. The member has been admitted to an institution where he/she is ineligible under the plan for further services.	**Suggested Documents:** • Coverage and authorization policies and procedures • Service Authorization Handbook • UM plan/UR policies and procedures • Advance NOABD letter template • NOABD turn-around-time tracking for previously authorized services • Three examples of an NOABD sent to a member for the termination, suspension, or reduction of a previously authorized service • Three examples of an NOABD sent to a member due to probable fraud *HSAG will also use the results of the service authorization file review **Documents Submitted for Desk Review:**	☒ Met ☐ Partially Met ☐ Not Met

Standard IV—Coverage and Authorization of Services (42 CFR §438.210)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
iv. The member's whereabouts are unknown, and the post office returns agency mail directed to him/her indicating no forwarding address. v. The agency establishes the fact that the member has been accepted for Medicaid services by another local jurisdiction, State, territory, or commonwealth. vi. A change in the level of medical care is prescribed by the member's physician. vii. The notice involves an adverse determination made with regard to the preadmission screening requirements. b. If probable member fraud has been verified, the CCO gives notice five (5) calendar days before the date of action. *42 CFR §438.404(c); §431.211; §431.213; §431.214* *Contract: Exhibit I(3)(b)(1)* *OAR 410-141-3885(5);(6)*	• Cascade Health Alliance Provider Handbook, page 36; Exceptions related to advance notice (ai-avii) • 15.Denials.thru.20221231 (highlighted Avg Days to Process). • 7.Q3 2022 Grievance and Appeals Exhibit I, NOABD Log tab & NOABD-Appeal Summary tab relate any NOABDs issued beyond 14 days. • 0.Grievance and Appeal System Binder 2022; Pg 35 sections 2.7, 2.7.1.1, 2.7.1.2, 2.7.1.2.1, 2.7.1.2.2, 2.7.1.3, 2.7.1.4, 2.7.1.9,2.7.1.6, 2.7.1.10, 2.7.2,	
HSAG Findings: *Grievance and Appeal System Binder*, *Appendix 4–Notice of Adverse Benefit Determination Application* procedure addressed the specific requirements of this element. During the site visit, the CCO reported that it did not deny or reduce services that had been previously approved. The CCO also confirmed that contracted benefits do not include long-term services (e.g., long-term services and supports, meal plans, etc.) that would be subject to termination or modification prior to the end of the authorization period. This requirement was *Met.*		
Required Actions: None.		
Recommendations: HSAG recommends that the CCO update its policy to reflect its current process, which includes upholding prior authorization decisions and not terminating or modifying services prior to the end of the authorization period.		

Standard IV—Coverage and Authorization of Services (42 CFR §438.210)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
14. The notice of adverse benefit determination must be in writing and meet the language and format requirements of 42 CFR §438.10(c). *42 CFR §438.404(a)* *Contract: Exhibit I(3)(a)(1)* *OAR 410-141-3835(10)(e)*	**Suggested Documents:** • Coverage and authorization policies and procedures • Service Authorization Handbook • NOABD letter template **Documents Submitted for Desk Review:** • 16.2021 NOABD Packet Template Approved, 17.NOABD Non Claims Feb 2023 (2022 template app by OHA Jan 2023) • 0.Grievance and Appeal System Binder 2022; Notice of Adverse Benefit Determination Application Procedure, Related Legislation and Documents (Pg 37) for all NOABD notices. • Cascaded Health Alliance Provider Handbook, page 35-36 • Cascade Health Alliance member Handbook page 53	☐ Met ☒ Partially Met ☐ Not Met
HSAG Findings: The *Grievance and Appeal System Binder*, *Appendix 4–Notice of Adverse Benefit Determination Application* procedure stated, "CHA writes notices in language sufficiently clear that a layperson could understand the notice and make an informed decision. This includes translating notices for members who speak non-English languages upon request. OHA defines 'easily understood' as sixth-grade reading level or lower using the Flesch-Kincaid readability scale. MCE uses a minimum 12-point font or large print (18 point). CHA's written materials include language access taglines in prevalent non-English languages in 18-point font …" File reviews revealed that NOABDs failed to meet language requirements for being easily understood, and the language access statement was missing. This requirement was *Partially Met.*		
Required Actions: The CCO must ensure all NOABDs sent to members by the CCO meet the language and readability requirements specified in this element.		

Standard IV—Coverage and Authorization of Services (42 CFR §438.210)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
Recommendations: HSAG recommends that the CCO implement processes to regularly monitor NOABDs to ensure notices meet the language and readability requirements.		
15. The notice of adverse benefit determination explains the following: a. Language access statement clarifying that oral interpretation is available for all languages and how to access it and a non-discrimination statement stating that CCO may not treat members unfairly due to their age, color, disability, gender identity, marital status, national origin, race, religion, sex, or sexual orientation; b. CCO contact information including name, address, and telephone number; c. Date of the notice; d. Name of the member's primary care provider (PCP), primary care dentist (PCD), or behavioral health professional if the member has an assigned practitioner. If the member has not yet been assigned a practitioner due to recent enrollment, the NOABD should state that PCP, PCD, or behavioral health professional assignment has not occurred; e. Member's name, date of birth, address, and OHP ID number; f. Description and explanation of the service(s) requested and the adverse benefit determination the CCO intends to make, including whether the CCO is denying, terminating, suspending, or reducing a service; g. Date the service was requested by the provider or member; h. Name of the provider who requested the service;	**Suggested Documents:** • Coverage and authorization policies and procedures • Service Authorization Handbook • NOABD letter template *HSAG will also use the results of the service authorization file review **Documents Submitted for Desk Review:** • 0.Grievance and Appeal System Binder 2022; Notice of Adverse Benefit Determination Application Procedure, Pg 34 Sections 2.5.8, 2.5.8.1, 2.6.1.1.2, 2.6.3, 2.6.4, 2.6.5, 2.6.6, Pg 33, 2.6.8, 2.6.9, 2.6.10, 2.6.11, 2.6.12, 2.6.13 • 16.2021 NOABD Packet Template Approved, Pg 2; • 17.NOABD Non Claims Feb 2023 (2022 template app by OHA Jan 2023), Pg 2 - 6 • 18.Language Access, • 19.Nondiscrimination Statement Notice 1.2022 • Cascaded Health Alliance Provider Handbook, page 35-36 • Cascade Health Alliance member Handbook page 53	☐ Met ☒ Partially Met ☐ Not Met

Standard IV—Coverage and Authorization of Services (42 CFR §438.210)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
i. Effective date of the adverse benefit determination if different from the date of the NOABD; j. Diagnosis and procedure codes submitted with the authorization request, including a description in plain language if the CCO is denying a requested service because of line placement on the prioritized list or the diagnosis and procedure code do not pair on the prioritized list; k. Other conditions CCO considered including but not limited to: co-morbidity factors if the service was below the funding line on the prioritized list; statement of intent governing the use and application of the prioritized list to requests for health care services including the placement of the condition/diagnosis code on the prioritized list; and other coverage for services addressed in the State 1115 Waiver; l. Clear and thorough explanation of the specific reasons for the adverse benefit determination; m. A reference to the specific sections of the statutes and administrative rules to the highest level of specificity for each reason and specific circumstances identified in the NOABD; n. The member's right or, if the member provides written consent as required under OAR 410-141-3890(1), the provider's right to file a written or oral appeal of CCO's adverse benefit determination with CCO, including information on exhausting CCO's one level of appeal, and the procedures to exercise that right; o. The member's or the provider's right to request a contested case hearing with OHA only after CCO's		

Standard IV—Coverage and Authorization of Services (42 CFR §438.210)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
notice of appeal resolution or where CCO failed to meet appeal timelines in OAR 410-141-3890 and 410-141-3895, and the procedures to exercise that right; p. The circumstances under which an expedited appeal resolution and an expedited contested case hearing are available and how to request; q. The member's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances under which the member may be required to pay the costs of the services; r. The member's right to receive from CCO, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the member's adverse benefit determination; and s. Copies of the appropriate forms as listed in OAR 410-141-3885. *42 CFR §438.404(b)* *Contract: Exhibit I(3)(a)(2)* *OAR 410-141-3835(10)(e)*		
HSAG Findings: The *Grievance and Appeal System Binder*, *Appendix 4–Notice of Adverse Benefit Determination Application* addressed the requirements of the NOABDs. However, file reviews of NOABDs from the CCO revealed the following omissions and/or misalignments with the CFR requirements: • Omission of a description and explanation of the service(s) requested. • Including unclear reasons for the denial (e.g., Your condition is on line "[number on prioritized list]" without further explanation). • Omission of right to grieve denial of expedited requests and extensions. • Omission of statement related to deemed exhaustion. The reviewer also noted that not all notices included diagnosis and procedure codes submitted with the authorization request. However, written notice requirements provided in the template from or at the direction of OHA will not be captured in the scoring for the CY 2023 compliance review. Furthermore, the compliance review finding will be limited to content that was not provided by or at the direction of OHA. However,		

Standard IV—Coverage and Authorization of Services (42 CFR §438.210)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
unmet requirements at the individual NOABD level led to unmet elements in this finding that will be captured in the scoring. This requirement was *Partially Met*.		
Required Actions: The CCO must ensure all NOABDs sent by the CCO and its subcontractors include the required content.		
Recommendations: HSAG recommends that the CCO review the most recent versions of its templates to ensure minimum State and federal requirements are captured. HSAG further recommends any omissions in the template should be discussed with OHA and will be assessed during the subsequent compliance review for this standard. HSAG also recommends that the CCO implement processes to regularly monitor NOABDs to ensure notices contain appropriate content and clearly communicate information to members.		
16. The CCO must provide appeal information to members in accordance with Ex. B, Part 3, Sec. 4 and, at a minimum, provide Members with the following information: a. The sixty (60) days' time limit for filing an Appeal; b. The toll-free numbers that the Member can use to file an Appeal by phone; c. The availability of assistance in the filing process; d. The process to request a Contested Case Hearing after an Appeal; e. The rules that govern representation at the Contested Case Hearing; and f. The right to have an attorney or Member Representative present at the Contested Case Hearing and the availability of free legal help through Legal Aid Services and Oregon Law Center, including the telephone number of the Public Benefits Hotline, 1-800-520-5292, TTY 711. *Contract: Exhibit I (4)(a)(4)*	**Suggested Documents:** • Appeal policies and procedures • Member materials, such as the member handbook • NOABD notices *HSAG will also review compliance through file reviews. **Documents Submitted for Desk Review:** • 0.Grievance and Appeal System Binder 2022; Appeal Procedure, page 17 sections 3.1, 3.1.1 - 3.1.4, 3.1.5, 3.1.6, 3.4, Pg. 23 section 4.2.6 • 16.2021 NOABD Packet Template Approved, Pg 2; • 17.NOABD Non Claims Feb 2023 (2022 template app by OHA Jan 2023), Pg 3 – 6 • Cascade Health Alliance member Handbook page 53 • Cascaded Health Alliance Provider Handbook, page 32-34	☒ Met ☐ Partially Met ☐ Not Met

Standard IV—Coverage and Authorization of Services (42 CFR §438.210)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
HSAG Findings: This requirement was *Met.*		
Required Actions: None.		
17. The CCO provides that compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual to deny, limit, or discontinue medically necessary services to any member. *42 CFR §438.210(e)* *Contract: Exhibit B Part 2(2)(d)* *OAR 410-141-3835(9)(d)*	**Suggested Documents:** • UM plan/UR policies and procedures • UM staff messaging/training materials • Three examples of staff attestations **Documents Submitted for Desk Review:** • Authorization.PP06001.pdf 3.4 • Cascade Health Alliance Member Handbook, page 58 Section Provider Incentives/Payment Methodologies	☒ Met ☐ Partially Met ☐ Not Met
HSAG Findings: This requirement was *Met.*		
Required Actions: None.		
18. The MCE provides response within 24 hours of a request for authorization for all covered outpatient drug authorization decisions as described in Section 1927(d)(5)(A) of the Social Security Act: Provide response by telephone or other telecommunication device within 24 hours of request for prior authorization. *42 CFR §438.210(d)(3)* *42 U.S. Code §1396r-8(d)(5)* *Contract: Exhibit B Part 2(3)(b)(13)* *OAR 410-141-3835(10)(b)*	**Suggested Documents:** • Coverage and authorization policies and procedures • Service Authorization Handbook • UM plan/UR policies and procedures • Pharmacy authorization turn-around-time tracking *HSAG will also use the results of the prior authorization and denial file review **Documents Submitted for Desk Review:** • Outpatient.Drug.Authorization.Decision.PP08002 Sections 3.2, 4.4, 5.2, 5.4,	☒ Met ☐ Partially Met ☐ Not Met

Standard IV—Coverage and Authorization of Services (42 CFR §438.210)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	• Standard IV Element 3 2022 Guidelines • Standard IV Element 18 2022 Index Audits	
HSAG Findings: This requirement was *Met.*		
Required Actions: None.		

Results for Standard IV—Coverage and Authorization of Services							
Total	Met	=	13	X	1.0	=	13.0
	Partially Met	=	5	X	0.5	=	2.5
	Not Met	=	0	X	0.0	=	0.0
Total Applicable		=	18	**Total Score**		=	15.5

Total Score ÷ Total Applicable	=	**86.1%**

Standard VII—Member Rights and Protections

Standard VII—Member Rights and Protections (42 CFR §438.100)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
1. The CCO has written policies regarding the member rights specified in this standard, complies with all federal and State laws, and contractual requirements, that pertain to member rights, and ensures that employees and contracted providers observe and protect those rights. In addition to written policies, the CCO must: a. Communicates these policies and procedures to employees and participating providers; and b. Monitor compliance with these policies and procedures, take corrective action as needed, and report findings to the Quality Improvement Committee (QIC) defined under OAR 410-141-3525. *42 CFR §438.100(a)(1) and (2)* *Contract: Exhibit B Part 3 (2)* *OAR 410-141-3590 (1)*	**Suggested Documents:** • Member rights policies and procedures • Provider communications, such as, the provider manual and relevant training materials • Employee training materials • Compliance monitoring mechanisms (grievances) • QIC meeting minutes related to member rights **Documents Submitted for Desk Review:** • Member.Rights.PP13006 pg 1 section 3.1 & 3.2; pg 2 section 3.18 • Provider Manual_Feb 2022_Standard VII (Pgs. 10-11; link on Pg. 32) • Member Rights Policy- Training Website Screenshot • UR Minutes 6.19.22 – Notes • Clinical.Practice.Guidelines.PP12001final20210428	☒ Met ☐ Partially Met ☐ Not Met
HSAG Findings: This requirement was *Met*.		
Required Actions: None.		

Standard VII—Member Rights and Protections (42 CFR §438.100)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
2. The CCO's policies and procedures ensure that each member is guaranteed the right to: a. Be treated with respect and with due consideration for his or her dignity and privacy. b. Receive information in accordance with information requirements (42 CFR §438.10). c. Receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition, preferred language, and ability to understand. d. Participate in decisions regarding his or her healthcare, including the right to refuse treatment, including: i. Being actively involved in the development of treatment plans and have family involved in such treatment planning. ii. Having the opportunity to execute a statement of wishes, including the right to accept or refuse medical, surgical, or behavioral health treatment iii. Executing directives and powers of attorney for health care established under ORS 127.505 to 127.660 and the Omnibus Budget Reconciliation Act of 1990 -- Patient Self-Determination Act. e. Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation. f. Request and receive a copy of his or her medical records and request that they be amended or corrected. g. Be furnished with health care services in accordance with § 438.206 through 438.210.	**Suggested Documents:** • Member rights policies and procedures • Member handbook • Other applicable member materials • Provider manual **Documents Submitted for Desk Review:** • Member.Rights.PP13006 (pg 1-2 section 3.1-3.19) • Enrollee.Rights.PP13006.01 (pg 1-3) document • 08.CHA.Member.Handbook.202204_Standard VII (Pgs. 9-11). • Provider Manual_Feb 2022_Standard VII (Pgs. 10-11; link on Pg. 32) • 18.Language Access (2.f) • 19.Nondiscrimination Statement Notice 1.2022 (2.f) • Non.Discrimination.PP07014, (1.1 pg 1, ,7.5 pg 3) • 20.Dissemination of Information Binder 2022, • 21.CHA ROI Approved (2.f)	☐ Met ☒ Partially Met ☐ Not Met

Standard VII—Member Rights and Protections (42 CFR §438.100)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
h. Choose their own health professional from available participating providers and facilities to the extent possible and appropriate. i. Be made aware of their civil rights under Title VI of the Civil Rights Act and ORS Chapter 659A and has a right to report a complaint of discrimination by contacting Contractor, OHA, the Bureau of Labor and Industries, or the Office of Civil Rights. *42 CFR §438.100(b)(2-3)* *Contract Exhibit B Part 3 (2)* *OAR 410-141-3590 (2)*		
HSAG Findings: The CCO's *Member Rights* policy listed some of the rights listed in the element but omitted the rights to have family involved in treatment planning; to have the opportunity to execute a statement of wishes, including the right to accept or refuse medical, surgical, or behavioral health treatment; and to execute directives and powers of attorney for health care. The CCO also submitted its *Enrollee Rights* policy, which was redundant to the *Member Rights* policy and written for an OHP member audience rather than as policy. During the site review, CCO staff members explained that according to their policy numbering system, the *Enrollee Rights* policy fell under the umbrella of the *Member Rights* policy and that the *Member Rights* policy was considered the primary policy. However, the *Enrollee Rights* policy was not compliant with the requirement or in alignment with the *Member Rights* policy, omitting the rights to be treated with consideration of privacy; to receive a copy of medical records; to be made aware of civil rights under Title VI of the Civil Rights Act and ORS Chapter 659A; and the right to report a complaint of discrimination by contacting the CCO, OHA, the Bureau of Labor and Industries (BOLI), or the Office of Civil Rights (OCR). While CHA's member handbook provided all of the rights listed in the element, this was not a substitute for policy. CHA's provider manual included a two-page excerpt from the CHA member handbook addressing member rights. However, the excerpt in the provider manual did not fully match the language of the *Member Rights* policy, *Enrollee Rights* policy, or member handbook and did not fully meet the requirements of the element. The provider manual did not state that members had the right to be treated with respect and with due consideration for their dignity and privacy (instead stating that members had the right "to be treated with dignity and respect the same as any other patients"); to receive a copy of their medical records; to be made aware of their civil rights under Title VI of the Civil Rights Act and ORS Chapter 659A; and to report a complaint of discrimination by contacting Contractor, OHA, BOLI, or OCR. This requirement was *Partially Met*.		
Required Actions: CHA must ensure that all member rights listed in the requirement are included in and consistent across relevant policies and procedures, the member handbook, and provider manual, including the rights to be treated with respect and due consideration for dignity and		

Standard VII—Member Rights and Protections (42 CFR §438.100)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
privacy; to receive copies of medical records; civil rights including the right to submit a civil rights grievance; to have family involved in treatment planning; to have the opportunity to execute a statement of wishes including the right to accept or refuse medical, surgical, or behavioral health treatment; and to execute directives and powers of attorney for health care. CHA must also ensure that any policies relating to member rights are neither competing nor contradictory.		
3. The CCO ensures that each member is free to exercise his or her rights and that the exercise of those rights does not adversely affect the way the CCO, its network providers, or the State treats the member. *42 CFR §438.100(c)* *Contract: Exhibit B Part 3 (2)(o)*	**Suggested Documents:** • Member rights policies and procedures • Member handbook • Other applicable member materials **Documents Submitted for Desk Review:** • Member.Rights.PP13006 (pg 2 section 3.17) • CHA.Member.Handbook.202204 (pg. 9-11)	☐ Met ☒ Partially Met ☐ Not Met
HSAG Findings: The CCO's *Member Rights* policy stated that members are free to exercise their rights and that exercising those rights would not adversely affect the way the CCO, its network providers, or the State Medicaid agency treats the member. The member handbook reflected this policy and encouraged members to file a grievance if they felt their rights were not respected. However, while the provider manual offered an excerpt on member rights and stated it was from the member handbook, the excerpt did not include the statement that members were free to exercise their rights without adverse effects. This requirement was *Partially Met*.		
Required Actions: The CCO must update its provider manual to clearly state that members are free to exercise their rights and that exercising those rights would not adversely affect how the CCO, its network providers, or the State treats the member.		
4. The CCO has written policies regarding compliance with other federal and State laws and must: a. Provide written notice to members of CCO's nondiscrimination policy and process to report a complaint of discrimination on the basis of race, color, national origin, religion, sex, sexual orientation, marital status, age, or disability in accordance with all applicable laws Title VI of the Civil Rights Act and ORS Chapter 659A by contacting the MCE, OHA, the Bureau of Labor and Industries, or the Office of Civil Rights.	**Suggested Documents:** • Nondiscrimination policies and procedures • Provider communications, such as, the provider manual • Member communications, such as the Nondiscrimination notice and member handbook • Provider contract • Provider manual	☒ Met ☐ Partially Met ☐ Not Met

Standard VII—Member Rights and Protections (42 CFR §438.100)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
b. Provide equal access for both males and females under 18 years of age to appropriate facilities, services and treatment under the CCO Contract, consistent with OHA obligations under ORS 417.270. c. Comply with any other federal and State laws that pertain to member rights including Title VI of the Civil Rights Act of 1964 as implemented by regulations at 45 CFR part 80; the Age Discrimination Act of 1975 as implemented by regulations at 45 CFR part 91, the Rehabilitation Act of 1973, Title IX of the Education Amendments of 1972 (regarding education programs and activities), Titles II and III of the Americans with Disabilities Act; and section 1557 of the Patient Protection and Affordable Care Act and ensures that its employees and contracted providers observe and protect members' rights. *42 CFR §438.100(a)(2);(d)* *Contract: Exhibit B Part 3 (2)(b-d)*	• Grievances related to discrimination **Documents Submitted for Desk Review:** • 19.Nondiscrimination Statement Notice 1.2022 • 8.CHA.Member.Handbook.202204_Standard VII (Pg. 9-11; 47). • Provider Manual_Feb 2022_Standard VII (Pg. 21) • Non.Discrimination.PP07014 (Pg. 2 section 6.1-6.2, and 7) • Member.Rights.Responsibilities.PP13006 (pg. 2 section 3.18-3.19, 4.4-4.4.1) • Enrollee.Rights.Responsibilities.PP13006.01 (pg. 1 2.1) • CHA Rogue Valley Surgery Center Agreement	
HSAG Findings: This requirement was *Met*.		
Required Actions: None.		
5. The CCO maintains written policies and procedures concerning advance directives with respect to all adult individuals receiving medical care by or through the CCO. The CCO's policies, procedures and written information provided to adult members include the following: a. Members' rights under the State (advance directives) law to make decisions concerning medical care, including the right to refuse or accept treatment and the right to formulate advance directives.	**Suggested Documents:** • Advance directive policies and procedures • Member handbook • Other member materials related to advance directives • Staff training or orientation materials related to advance directives	☐ Met ☒ Partially Met ☐ Not Met

Standard VII—Member Rights and Protections (42 CFR §438.100)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
b. The CCO's written policies respecting the implementation of those rights, including a clear and precise statement of limitation if the CCO cannot implement an advance directive as a matter of conscience. At a minimum, this statement must do the following: i. Clarify the difference between institution-wide conscientious objections and those raised by individual physicians. ii. Identify the State legal authority permitting such objection. iii. Describe the range of medical conditions or procedures affected by the conscientious objection. c. Provisions for providing information regarding advance directives to the member's family or surrogate if the member is incapacitated at the time of initial enrollment due to an incapacitating condition or mental disorder and unable to receive information. d. Provisions for providing advance directive information to the incapacitated member once he or she is no longer incapacitated, and follow-up procedures in place to ensure that the information is given to the individual directly at the appropriate time. e. Provisions for documenting in a prominent part of the member's medical record whether or not the member has executed an advance directive. f. Provisions that the decision to provide care to a member is not conditioned on whether the member has executed an advance directive, and that members are not	• Evidence of community education about advance directives **Documents Submitted for Desk Review:** • Advance.Directive.PP12003; (pg. 1 section 1.1, 3.1, 3.4, pg 2 section 3.6.1- 3.6.3, 4.2.1-4.3.1, pg 3 section 4.8-4.8.1, 4.11-4.11.1.9, pg. 3/4 section 4.12, pg. 4/5 section 6.1, 6.7, pg) • Enrollee Rights Policy PP13006.01 (Pg 2) • 08. CHA.Member.Handbook. 202204_Standard VII (Pg. 42).	

Standard VII—Member Rights and Protections (42 CFR §438.100)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
discriminated against based on whether they have executed an advance directive. g. Provisions for ensuring compliance with State laws regarding advance directives. h. Provisions for informing members of changes in State laws regarding advance directives as soon as possible, but no later than **90 days** following the changes in the law. i. Provisions for the education of staff concerning its policies and procedures on advance directives. j. Provisions for community education regarding advance directives that include: i. What constitutes an advance directive. ii. Emphasis that an advance directive is designed to enhance an incapacitated individual's control over medical treatment. iii. Description of applicable State law concerning advance directives. k. Complaints regarding advance directives may be filed with the State Survey Agency. l. Information must be provided to the member at the time of the initial enrollment. *42 CFR §438.3(j)* *42 CFR §422.128* *Contract: Exhibit E (14)*		
HSAG Findings: CHA's *Advance Directive* policy articulated the right of members to create a statement of wishes for treatment, including an advance directive or other document describing the member's wishes for care at the end of life or due to incapacitation, including the right to accept or reject health care and the right to appoint another individual to make executive decisions on behalf of the member. The policy included the statement that the CCO is not to object as a matter of conscience to any advance directive or limit the implementation of advance directives. The policy required that providers make information available to adult members, including advance directives, and that staff and		

Standard VII—Member Rights and Protections (42 CFR §438.100)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
providers are to respect and support the rights of members in this regard. However, the policy did not specify to which provider types the requirement applied (as referenced in 42 CFR §422.128 and defined in 42 CFR §489.102—hospitals, critical access hospitals, skilled nursing facilities, nursing facilities, home health agencies, providers of home health care [and for Medicaid purposes, providers of personal care services], hospices, and religious nonmedical health care institutions). The policy included a statement that information on advance directives is to be provided to members via the member handbook, CCO website, provider offices, hospitals, case managers, behavioral health providers, and chemical dependency providers. This procedure asserted that information is also to be provided to the member's family or surrogate if the member were incapacitated at the time of enrollment and to the member should they no longer be incapacitated. However, neither the CCO's *Advance Directive* policy nor the provider agreement nor the provider manual addressed the provider's responsibility to supply advance directive information to an incapacitated member's family or surrogate. Additionally, CCO staff did not articulate a process for how providers would be informed about advance directive requirements. The policy stated that documentation of an advance directive is to be prominently displayed in the member's record. However, it was unclear how providers would be made aware of this requirement. The policy stated that CHA is not to require members to have an advance directive, and that the care members receive is not to be predicated on the presence or absence of an advance directive. The policy required providers to comply with State laws regarding advance directives. Although the policy stated that the CCO is to inform members of changes in State laws regarding advance directives no later than 90 days following the changes in the law, it did not provide a process for how the CCO would do so or track timeliness of such communication, and CCO staff members did not articulate a cohesive process during the site visit. The CCO's policy correctly stated that it is not within the CCO's scope to directly help members to complete an advance directive, and ensured that staff are to be trained to direct members to case managers and intensive care management (ICM) for assistance, who then are to coordinate meetings between the relevant parties (i.e., members, family, and providers) to support completion of an advance directive. During the site review, CCO staff stated that the primary avenue for offering education on advance directives was through the member handbook. The CCO's policy identified the appropriate State agency for filing any grievances related to advance directives, including contact information. CHA's member handbook reflected the CCO's *Advance Directive* policy regarding the right of members to create an advance directive or other document describing the member's wishes for care at end of life or due to incapacitation, including the right to accept or reject health care and the right to appoint another individual to make executive decisions on behalf of the member. The handbook provided contact information for filing any grievances related to advance directives with OHA. However, the member handbook did not state that members would not be required to have an advance directive or that services would not be performed unless the member had an advance directive. The provider handbook stated that members had a right to create an advance directive but did not provide further information on provider responsibilities to comply with 42 CFR§489.102, including the requirement for applicable providers (as listed above) to supply members with information on advance directives and to maintain written policies and procedures concerning advance directives with respect to all adult individuals receiving medical care, or patient care. Similarly, neither the provider handbook nor the sample provider agreement required	

Standard VII—Member Rights and Protections (42 CFR §438.100)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
providers to supply the family or surrogate of an incapacitated member with information on advance directives, or to provide such information to a member who was no longer incapacitated. While the *Advance Directive* policy included the requirement to clearly annotate any advance directive information into medical records, neither the provider handbook nor sample provider agreement included the requirement. Neither the provider manual nor sample provider agreement stated that members would not be required to have an advance directive or that services would not be withheld if the member lacked an advance directive. The sample provider agreement stated that providers were required to comply with all advance directives pursuant to State law and regulations. This requirement was *Partially Met*.		
Required Actions: CHA must make the following updates to its policies, procedures, member-facing materials, and provider-facing materials: • Update its *Advance Directive* policy to: – Include the requirement for applicable providers (as referenced in 42 CFR §422.128 and defined in 42 CFR §489.102—hospitals, critical access hospitals, skilled nursing facilities, nursing facilities, home health agencies, providers of home health care [and for Medicaid purposes, providers of personal care services], hospices, and religious nonmedical health care institutions*)* to abide by the same policy and member information requirements regarding conscientious objections. – Include the requirement for applicable providers (as referenced in 42 CFR §422.128 and defined in 42 CFR §489.102—hospitals, critical access hospitals, skilled nursing facilities, nursing facilities, home health agencies, providers of home health care [and for Medicaid purposes, providers of personal care services], hospices, and religious nonmedical health care institutions) to provide advance directive information to a family member or surrogate when a member is incapacitated and provide information to the member once he or she is no longer incapacitated. The policy should also outline follow-up procedures to ensure the information is given to the member at the appropriate time. • Ensure provider-facing materials: – Inform providers of their obligation to comply with the CCO's policy and member information requirements regarding conscientious objections. – Inform providers of their obligations to provide advance directive information to family members or surrogates when a member is incapacitated and provide information to the member once he or she is no longer incapacitated. – Assert that the decision to provide care to a member is not conditioned on whether the member has executed an advance directive and that members may not be discriminated against based on whether they have executed an advance directive. – Clearly state the expectation that providers must comply with State laws governing compliance with honoring advance directives. – Clearly state the expectation that providers must prominently note in medical records whether a member has an advance directive. • Ensure member-facing materials:		

Standard VII—Member Rights and Protections (42 CFR §438.100)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
– Communicate that decisions to authorize or provide care are not conditioned on whether or not the member executed an advance directive and that members are not discriminated against based on whether they have an advance directive.		

Recommendations:

HSAG recommends, as a best practice, that CHA make the following changes:

- Update the *Advance Directive* policy and procedure to include how the CCO is to inform members of changes to advance directive laws and policies within 90 days other than via the annual member handbook.
- Incorporate advance directive information into community education plans, events, and materials.
- Use the OHA model member handbook as a source of truth for identifying the correct OHA department for submitting complaints related to advance directives.

Standard VII—Member Rights and Protections							
Total	Met	=	2	X	1.0	=	2.0
	Partially Met	=	3	X	0.5	=	1.5
	Not Met	=	0	X	0.0	=	0.0
Total Applicable		=	5	**Total Score**		=	3.5

Total Score ÷ Total Applicable	=	**70.0%**

Standard X—Grievance and Appeal Systems

Standard X—Grievance and Appeal Systems (42 CFR §438.228)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
1. The CCO has established internal grievance and appeal policies and procedures under which members, or providers acting on their behalf, may challenge the denial of coverage of, or payment for, medical assistance. The CCO must have a grievance and appeal system in place to handle appeals of an adverse benefit determination and grievances, as well as processes to collect and track information about them. The CCO must not: a. Discourage a member from using any aspect of the grievance, appeal, or hearing process. b. Encourage any member to withdraw a grievance, appeal, or contested case hearing request already filed. c. Use the filing or resolution of a grievance, appeal, or contested case hearing request as a reason to retaliate against a member or as a basis for requesting member disenrollment. d. Take punitive action against a provider who requests an expedited resolution or supports a member's grievance or appeal. *42 CFR §438.400(a)(3) and (b)* *Contract: Exhibit I* *OAR 410-141-3875 (10)* *OAR 410-141-3895 (2)*	**Suggested Documents:** • Grievance and appeal policies and procedures • Reports • (Throughout this standard, HSAG will use results from grievance and appeal record reviews to score the related requirements.) **Documents Submitted for Desk Review:** • 0. Grievance System Binder 2022, Pg 1 sections 1.1; 1.2; 3.1; NOABD Procedure (begins page 31), section 1.3 • 7.Q3 2922 Appeal & Grievance Exhibit 1 (Quarterly Reporting of Grievances, Appeals, and NOABDs – Sent to OHA each quarter,) • 4. CHA Provider Training Appeal & Grievances 2022; Slide 3 Summary of Grievances and Appeals, includes Non-Retaliation highlighted on Slide 7 • 3.CAC Board Agenda; Appeal, Grievance, & Hearing Training Power Point 11/15/22, Non-Retaliation highlighted on Slide 2	☒ Met ☐ Partially Met ☐ Not Met

Standard X—Grievance and Appeal Systems (42 CFR §438.228)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	• 5.CHA Staff Appeal & Grievance Training Power Point 5/6/22, Non-Retaliation highlighted on Slide 7	
HSAG Findings: This requirement was *Met*.		
Required Actions: None.		
2. The CCO defines "adverse benefit determination" as: a. The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit. b. The reduction, suspension, or termination of a previously authorized service. c. The denial, in whole or in part, of payment for a service. *A payment denied solely because the claim does not meet the definition of a clean claim under 42 CFR §447.45(b) is not an adverse benefit determination.* d. The failure to provide services in a timely manner, as defined by the State. e. The failure to act within the time frames defined by the State for standard resolution of grievances and appeals. f. For a resident of a rural area with only one CCO, the denial of a member's request to exercise his or her rights to obtain services outside the network under the following circumstances: i. The service or type of provider (in terms of training, expertise, and specialization) is not available within the CCO's network.	**Suggested Documents:** • Policies and procedures that address denials/adverse benefit determination • Staff training materials • Member handbook • Provider materials, such as provider manual **Documents Submitted for Desk Review:** • 0. Grievance System Binder 2022, Pg 8 section 6.5; Pg 32 sections 2.1, 2.2.1-2.2.3, Pg 31; 2.2.4-2.2.9, • 8.Member Handbook 2022: Appeals and Hearings NOABD, Pg 54; • Provider Manual_Feb 2022_Standard X (Pgs. 32-36).	☒ Met ☐ Partially Met ☐ Not Met

Standard X—Grievance and Appeal Systems (42 CFR §438.228)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
ii. The provider is not part of the network, but is the main source of a service to the beneficiary – provided that: – The provider is given the opportunity to become a participating provider under the same requirements for participation in the CCO's network as other providers of that type. – If the provider chooses not to join the network, or does not meet the qualification requirements, the member will be transitioned to a participating provider within 60 calendar days after being given the opportunity to choose a participating provider. g. The denial of a member's request to dispute a member's financial liability (cost-sharing, copayments, premiums, deductibles, coinsurance, or other). *42 CFR §438.400(b)* *42 CFR §438.52(b)(2)(ii)* *Contract: Exhibit A* *OAR 410-141-3875 (1)(b)*		
HSAG Findings: This requirement was *Met*.		
Required Actions: None.		
3. The CCO defines "appeal" as a review by the CCO of an adverse benefit determination. *42 CFR §438.400(b)* *Contract: Exhibit A* *OAR 410-141-3875 (1)(a)*	**Suggested Documents:** • Grievance and appeals policies and procedures • Staff training materials • Member handbook • Provider materials, such as provider manual	☒ Met ☐ Partially Met ☐ Not Met

Standard X—Grievance and Appeal Systems (42 CFR §438.228)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	Documents Submitted for Desk Review: • 0. Grievance System Binder 2022 Pg 8 section 6.1; Pg 16 section 1.1, • CAC Board Agenda; Appeal, Grievance, & Hearing Training Power Point 11/15/22, Appeals ,Slide 5 • 8.Member Handbook 2022: Appeals and Hearings, Pg 54 • Provider Manual_Feb 2022_Standard X (Pgs. 32,33).	
HSAG Findings: This requirement was *Met*.		
Required Actions: None.		
4. The CCO defines "grievance" as an expression of dissatisfaction about any matter other than an adverse benefit determination. a. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member's rights regardless of whether remedial action is requested. Grievance includes a member's right to dispute an extension of time proposed by the CCO to make an authorization decision. *42 CFR §438.400(b)* *Contract: Exhibit A* *OAR 410-141-3875 (1)(f)*	**Suggested Documents:** • Grievance and appeal policies and procedures • Staff training materials • Member handbook • Provider materials, such as provider manual **Documents Submitted for Desk Review:** • 0.Grievance System Binder 2022, Pg 8 section 6.2, Pg 10 section 2.1, 2.1.1,2.1.1.1, • 5.CHA Staff Appeal & Grievance Training Power Point 5/6/22, Grievances on Slide 2 & 7	☒ Met ☐ Partially Met ☐ Not Met

Standard X—Grievance and Appeal Systems (42 CFR §438.228)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	• 3.CAC Board Agenda; Appeal, Grievance, & Hearing Training Power Point 11/15/22, Grievances ,Slide 2 • Provider Manual_Feb 2022_Standard X (Pgs. 32).	
HSAG Findings: This requirement was *Met*.		
Required Actions: None.		
5. The CCO has provisions for who may file: a. A member may file a grievance (with the State or the CCO), a CCO-level appeal, and may request a contested case hearing. b. With the member's written consent, a provider or authorized representative may file a grievance (with the State or the CCO), an CCO-level appeal, and may request a contested case hearing on behalf of a member. *42 CFR §438.402(c)* *Contract: Exhibit I (1)(c)* *Contract: Exhibit I (1)(c)* *OAR 410-141-3880 (1)*	**Suggested Documents:** • Grievance and appeal policies and procedures • Member handbook • Provider materials, such as provider manual • Staff training materials **Documents Submitted for Desk Review:** • 0. Grievance System Binder 2022, • Pg 10, section 2.1, 2.1.1, 2.1.1.1, • 8.Member Handbook 2022: Appeals and Hearings, Pg 54 • Provider Manual_Feb 2022_Standard X (Pgs. 32-36). • 5.CHA Staff Appeal & Grievance Training Power Point 5/6/22, Grievances on Slide 4 • 3.CAC Board Agenda; Appeal, Grievance, & Hearing Training Power Point 11/15/22, Grievances, Slides 2 & 4	☒ Met ☐ Partially Met ☐ Not Met

Standard X—Grievance and Appeal Systems (42 CFR §438.228)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
HSAG Findings: This requirement was *Met*.		
Required Actions: None.		
6. The CCO must: a. Allow members to file a grievance at any time. *42 CFR §438.402(c)(2)(i)* *Contract: Exhibit I (1)(d)(1)* *OAR 410-141-3880 (1)*	**Suggested Documents:** • Grievance and appeal policies and procedures • Member handbook • Provider materials, such as provider manual • Staff training materials **Documents Submitted for Desk Review:** • 0. Grievance System Binder 2022, • Pg 10 sections 2.1, 2.1.1, 2.1.1.1, • 8.Member Handbook 2022: Appeals and Hearings, Pg 54 • 5.CHA Staff Appeal & Grievance Training Power Point 5/6/22, Grievances on Slide 2 • 3. CAC Board Agenda; Appeal, Grievance, & Hearing Training Power Point 11/15/22, Grievances ,Slide 2 • Provider Manual_Feb 2022_Standard X (Pgs. 32-36).	☐ Met ☒ Partially Met ☐ Not Met
HSAG Findings: CHA's *Grievance and Appeal System* policy stated that clinical or non-clinical grievances may be filed at any time. Although the member handbook included the time frames for responding to grievances, the member handbook did not inform members that grievances can be filed at any time. The provider manual also did not communicate that members can file a grievance at any time. This requirement was *Partially Met*.		
Required Actions: The CCO must revise its member handbook to communicate that members may file grievances at any time.		

Standard X—Grievance and Appeal Systems (42 CFR §438.228)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
Recommendations: As a best practice, the CCO should state that members can file a grievance at any time in the provider manual.		
7. The CCO must: a. Accept grievances orally or in writing. *42 CFR §438.402(c)(3)(i)* *Contract: Exhibit I (e)(2)* *OAR 410-141-3880 (1)*	**Suggested Documents:** • Grievance and appeal policies and procedures • Member handbook • Provider materials, such as provider manual • Grievances and appeals turn-around-time tracking • Staff training materials *HSAG will also assess compliance through file reviews. **Documents Submitted for Desk Review:** • 0.Grievance System Binder 2022, Pg 10, 2.1, • 8.Member Handbook 2022: Appeals and Hearings, Pg 54 • 7.Q3 2022 Grievance and Appeals Exhibit I, Grievance Log (tab 3) • 5.CHA Staff Appeal & Grievance Training Power Point 5/6/22, Grievances on Slide 4 • 3. CAC Board Agenda; Appeal, Grievance, & Hearing Training Power Point 11/15/22, Grievances, Slide 2 • Provider Manual_Feb 2022_Standard X Pg. 32	☒ Met ☐ Partially Met ☐ Not Met
HSAG Findings: This requirement was *Met*.		
Required Actions: None.		

Standard X—Grievance and Appeal Systems (42 CFR §438.228)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
8. The CCO provides written acknowledgement of grievance within five business days providing the following information: a. An explanation of the decision; or b. Informing the member that a decision will be made within 30 calendar days from the date of the CCO's receipt of the grievance and the reason additional time is necessary. **The CCO may provide its decision related to oral grievances orally but must also respond to oral grievances in writing.* *42 CFR §438.406(b)(1)* *Contract: Exhibit I (2)(f)(1* *OAR 410-141-3880(2)*	**Suggested Documents:** • Grievance and appeal policies and procedures • Member handbook • Provider materials, such as provider manual • Grievances and appeals turn-around-time tracking • Staff training materials *HSAG will also assess compliance through file reviews. **Documents Submitted for Desk Review:** • Q3 2022 Grievance and Appeals Exhibit I, Grievance Log (tab 3), # Days to Resolution & Actual Days Resolved, Within 5 Days, 6 to 30 Days, and Over 30 Days Columns, Grievance Summary Totals (tab 4) % Resolved within 5 Business Days, % Resolved between 6 & 30 calendar days, & % Resolved past 30 days Columns. • 0.Grievance System Binder 2022 , Pg 11, sections 3.4, 3.4.1, 3.4.4.4, 3.4.1.2, • 8.Member Handbook 2022: Appeals and Hearings, Pg 54 • 5.CHA Staff Appeal & Grievance Training Power Point 5/6/22, Grievances on Slide 3	☐ Met ☒ Partially Met ☐ Not Met
HSAG Findings: CHA's *Grievance and Appeal System* policy stated that the CCO is to send a written acknowledgment of grievances within five days of receipt of members' grievances. The *Grievance and Appeal System* policy also described that the acknowledgment letter is to		

Standard X—Grievance and Appeal Systems (42 CFR §438.228)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
explain the resolution of the grievance or that the CCO needs additional time to resolve the grievance, and that a final decision will be made within 30 days. The member handbook informed members that the CCO provides acknowledgment letters within five days to members and/or their representatives. Neither the provider manual nor the provider training discussed that acknowledgment letters are sent within five days of receipt of the grievance. The CCO's grievance log demonstrated that the CCO tracked grievance resolution time frames. However, the grievance log did not demonstrate monitoring of compliance with the acknowledgment letter time frame. The record review revealed that the CCO's subcontractors were missing acknowledgement letters or sent them outside of the required time frame. The requirement was *Partially Met*.		
Required Actions: The CCO must monitor and ensure that acknowledgment letters are sent within five business days.		
Recommendations: As a best practice, HSAG recommends that the CCO inform providers in the provider manual and provider training of the acknowledgment letter time frames.		
9. The CCO provides written notice of grievance resolution as expeditiously as the members health requires, or no later than 30 calendar days from the day in which the CCO receives the grievance. **The CCO may provide its decision related to oral grievances orally but must also respond to oral grievances in writing.* *42 CFR §438.408 (b)(1)* *Contract: Exhibit I (2)(f)(2)(a)* *OAR 410-141-3880 (2)*	**Suggested Documents:** • Grievance and appeal policies and procedures • Member handbook • Provider materials, such as provider manual • Grievances and appeals turn-around-time tracking • Staff training materials *HSAG will also assess compliance through file reviews. **Documents Submitted for Desk Review:** • 0.Grievance System Binder 2022, Pg 11, sections 3.4, 3.4.1, 3.4.4.4, 3.4.1.2, • 8.Member Handbook 2022: Appeals and Hearings, Pg 54 • Q3 2022 Grievance and Appeals Exhibit I, Grievance Log (tab 3), # Days to Resolution	☐ Met ☒ Partially Met ☐ Not Met

Standard X—Grievance and Appeal Systems (42 CFR §438.228)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	& Actual Days Resolved, Within 5 Days, 6 to 30 Days, and Over 30 Days Columns, Grievance Summary Totals (tab 4) % Resolved within 5 Business Days, % Resolved between 6 & 30 calendar days, & % Resolved past 30 days Columns • 5.CHA Staff Appeal & Grievance Training Power Point 5/6/22, Grievances on Slide 3 Training materials AG Staff Training • 4.CHA Provider Training Appeal,Grievance,Recons Power Point 11/22, Grievances and Appeals Slide 3. • 3.CAC Board Appeal Grievance & Hearing Training Power Point 11.15.22, Slide 3. • 12.Grievance Acknowledgement Letter • 13.Grievance Resolution Letter • 11 Grievance Dashboard thru 20220930, Average Resolution (Days), Pg 1	
HSAG Findings: CHA's *Grievance and Appeal System* policy sufficiently addressed that the CCO is to provide written notice of the grievance resolution, as expeditiously as the member's health requires, but within 30 calendar days from the date it received the original grievance. The member handbook and grievance and appeal staff training PowerPoint (PPT) also communicated the appropriate grievance resolution time frame. However, the provider manual and training PPT did not include that the CCO would send a written notice of grievance resolution to all members in 30 calendar days of receipt of a grievance. The CCO's grievance log demonstrated that the CCO tracked grievance resolution time frames. However, the record review revealed that the CCO's subcontractors did not send out resolution letters for some member grievances. The requirement was *Partially Met*.		
Required Actions: The CCO must provide written notice of grievance resolution as expeditiously as the members' health requires or no later than 30 calendar days from the day the CCO receives the grievance.		

Standard X—Grievance and Appeal Systems (42 CFR §438.228)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
Recommendations: As a best practice, HSAG recommends the CCO inform providers in the provider manual and provider training of the grievance resolution time frames.		
10. The grievance resolution notice must meet the following requirements: a. The notice shall address each aspect of the member's grievance and explain the reason for CCO's decision. b. The language in the notice shall be sufficiently clear that a layperson could understand the disposition of the grievance. i. The notice must be in a format and language that may be easily understood by the member. c. The notice shall advise all affected members that they have the right to present their grievance to OHP Client Services Unit (CSU) or OHA's Ombudsperson by telephone. Such telephone numbers shall be included in the notice and are as follows: i. For CSU: 800-273-0557, and ii. For OHA's Ombudsperson: 503-947-2346 or toll free at 877-642-0450. *42 CFR §438.408 (d)(1)* *Contract: Exhibit I (2)(f)(2)* *OAR 410-141-3880 (4)*	**Suggested Documents:** • Grievance policies and procedures • Grievance resolution notice template *HSAG will also assess compliance through file reviews. **Documents Submitted for Desk Review:** • 0.Grievance System Binder 2022, Pg 12, sections 3.4.1, 3.4.1.1, 3.4.2, 3.4.4, 3.4.5, 3.4.5.1, 3.5.2, • 13.Grievance Resolution Letter	☐ Met ☒ Partially Met ☐ Not Met
HSAG Findings: The *Grievance and Appeal System* policy stated that the Notice of Grievance Resolution is to be provided in accordance with Oregon Health Authority's Formatting and Readability Standards and in the member's preferred language information and the language of the letter must be clear that a layperson can understand the disposition of the grievance. However, the policy did not list the notice requirements addressed in this element. The record review revealed that the CCO's grievance resolution letters were not in the appropriate font size, missing the language accessibility statement, and the right to present the grievance to the CSU or Ombudsperson. Although there were missing statements in the templates and the font size was not met for the 2023 review, at the direction of OHA, written notice requirements provided in the template from or at the direction of OHA will not be captured in the scoring for the 2023 compliance review. However, other unmet		

Standard X—Grievance and Appeal Systems (42 CFR §438.228)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
elements, such as policy omissions and failure to attach the language access taglines to the letters, led to the required actions for this review. The requirement was *Partially Met*.		
Required Actions: The CCO must revise applicable policies to address the grievance resolution notice requirements outlined in (a)-(c) of this requirement. The CCO must also ensure language access taglines are attached to grievance resolution notices.		
Recommendations: HSAG recommends that the CCO review the most recent versions of its templates to ensure minimum federal and State requirements are captured; any omissions in the template should be discussed with OHA and will be assessed during the following compliance review for this standard. The CCO should also ensure that it implements the appropriate version of the template.		
11. In handling grievances and appeals, the CCO must give members reasonable assistance in completing any forms and taking other procedural steps related to a grievance or appeal. This includes, but is not limited to, auxiliary aids and services upon request, providing interpreter services and toll-free numbers that have adequate Teletypewriter/ Telecommunications Device for the Deaf (TTY/TDD) and interpreter capability. *42 CFR §438.406(a)* *Contract: Exhibit I (1)(e)(5)* *OAR 410-141-3875(9)*	**Suggested Documents:** • Grievance and appeals policies and procedures • Member handbook • Provider materials, such as provider manual *HSAG will also assess compliance through file reviews. **Documents Submitted for Desk Review:** • 0.Grievance System Binder 2022 • Pg 2 sections 3.3.3, 3.3.3.1, • 8.Member Handbook 2022: Appeals and Hearings, Pg 54 • Provider Manual_Feb 2022_Standard X Pg. 32	☒ Met ☐ Partially Met ☐ Not Met
HSAG Findings: This requirement was *Met*.		
Required Actions: None.		

Standard X—Grievance and Appeal Systems (42 CFR §438.228)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
12. The CCO ensures that the individuals who make decisions on grievances and appeals are individuals who: a. Were not involved in any previous level of review or decision-making nor a subordinate of any such individual. b. Have the appropriate clinical expertise, as determined by the State, in treating the member's condition or disease if deciding any of the following: i. An appeal of a denial that is based on lack of medical necessity. ii. A grievance regarding the denial of expedited resolution of an appeal. iii. A grievance or appeal that involves clinical issues. c. Take into account all comments, documents, records, and other information submitted by the member or his or her representative without regard to whether such information was submitted or considered in the initial adverse benefit determination. *42 CFR §438.406(b)(2)* *Contract: Exhibit I (1)(e)(8-9)* *OAR 410-141-3875(5)(d)*	**Suggested Documents:** • UR policies and procedures • Grievance and appeals policies and procedures *HSAG will also review compliance through file reviews. **Documents Submitted for Desk Review:** • 14.Reconsideration.PP02014 Pg 3 sections 4.9, 4.9.1, 4.9.2 • 0.Grievance System Binder 2022, • Pg 13 sections 4.1.2, 4.1.3, 4.1.3.1, 4.1.3.2, 4.1.3.3,4.1.4, 4.1.5, 4.1.6, 4.1.7,	☐ Met ☒ Partially Met ☐ Not Met
HSAG Findings: CHA's *Grievance and Appeal System* policy appropriately addressed that the CCO is to ensure the individuals who make decisions on grievances and appeals were not involved in previous levels of review and have the appropriate clinical expertise to make decisions. The policy also stated that the CCO is to consider all comments, documents, records, and other information submitted by members or their representatives without regard to whether such information was submitted or considered in the initial adverse benefit determination. The *Reconsideration* policy stated that the professionals who make the decisions to uphold appeals and reconsiderations are not involved in previous levels of review that resulted in an adverse determination. However, the policy stated that individuals involved in previous levels of decision-making that resulted in an adverse benefit determination can be involved in overturning that decision. This policy statement does not align with the requirement to ensure that decision-makers were not involved in any previous level of review or decision-making. In addition, the		

Standard X—Grievance and Appeal Systems (42 CFR §438.228)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
Reconsideration policy does not address the requirement to ensure that the individuals making decisions on grievances and appeals are not subordinates of the individuals who made the decision on the previous level of review. Additionally, the record review revealed that the CCO did not have the appropriate decision-maker on clinically related grievances. It also was found that the CCO used a subordinate of the previous decision maker to review an appeal of the previous decision, which does not align with the requirement. The requirement was *Partially Met*.		
Required Actions: The CCO must revise its *Reconsideration* policy and ensure that the individuals making decisions on grievances and appeals are not involved in any previous levels of review or decision-making nor a subordinate of any such individual. Further, decision-making individuals must have the appropriate clinical expertise, as determined by the State, in treating the member's condition or disease if deciding on a grievance that involves clinical issues.		
13. A member may file an appeal with the CCO within 60 calendar days from the date on the notice of adverse benefit determination. *42 CFR §438.402(c)(2)(ii)* *Contract: Exhibit I (1)(d)(2)* *OAR 410-141-3890 (6)(b)*	**Suggested Documents:** • Grievance and appeal policies and procedures • Member handbook • Provider materials, such as provider manual • Training materials *HSAG will also review compliance through file reviews. **Documents Submitted for Desk Review:** • 0.Grievance System Binder 2022, Pg 17, 3.4 • 8.Member Handbook 2022: Appeals and Hearings, Pg 54 • 5.CHA Staff Appeal & Grievance Training Power Point 5/6/22, Appeals & Reconsiderations on Slide 11. • 4.CHA Provider Training Appeal,Grievance,Recons Power Point 11/22, Grievances and Appeals Slide 3.	☒ Met ☐ Partially Met ☐ Not Met

Standard X—Grievance and Appeal Systems (42 CFR §438.228)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	• 3.CAC Board Appeal Grievance & Hearing Training Power Point 11.15.22, Slide 6.	
HSAG Findings: This requirement was *Met*.		
Required Actions: None.		
14. The member may file an appeal either orally or in writing, and the CCO must treat oral appeals in the same manner as appeals received in writing. The CCO may not require that oral requests for an appeal be followed with a written appeal. *42 CFR §438.402(c)(3)(ii); 438.406(b)(3)* *Contract: Exhibit I (1)(e)* *OAR 410-141-3890 (6)*	**Suggested Documents:** • Member handbook • Grievance and appeal policies and procedures • Provider materials, such as provider manual • Training materials *HSAG will also review compliance through file reviews. **Documents Submitted for Desk Review:** • 8.Member Handbook 2022: Appeals and Hearings, Pg 54 • 0.Grievance System Binder 2022, Pg 16, 2.1, • 18. Grievance and Appeal System Binder 2023, Appeal Procedure, 2.1, 2.1.1 Pg 21 relates full verbiage Grievance (the 2023 P&P was submitted 3/1/23, it hasn't been approved yet). • Provider Manual_Feb 2022_Standard X Pg. 32 • 5.CHA Staff Appeal & Grievance Training Power Point 5/6/22, Appeals & Reconsiderations on Slide 11.	☒ Met ☐ Partially Met ☐ Not Met

Standard X—Grievance and Appeal Systems (42 CFR §438.228)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	• 4.CHA Provider Training Appeal,Grievance,Recons Power Point 11/22, Grievances and Appeals Slide 3. • 3.CAC Board Appeal Grievance & Hearing Training Power Point 11.15.22, Slide 6. • 17.NOABD Non Claims 2022 App Feb 2023 (This is our 2022 Template that OHA approved 1/2023), Pg 4.	
HSAG Findings: This requirement was *Met*.		
Required Actions: None.		
15. The CCO acknowledges receipt of each appeal in writing within the following timeframes: a. For non-expedited/standard appeals: in writing within five business days of receipt, and b. For all expedited appeals: orally and in writing within one business day of receipt. *42 CFR §438.406(b)(1)* *Contract: Exhibit I (4)(a)(1)*	**Suggested Documents:** • Grievance and appeal policies and procedures • Training materials *HSAG will also review compliance through file reviews. **Documents Submitted for Desk Review:** • 0.Grievance System Binder 2022, • Pg 18 sections 3.6.10.1, 3.6.10.2 • Pg 20, sections 3.6.3, • 19.Appeal Acknowledgment Letter (Expedited Appeal) Pg 1; • 20.Case Summary (Expedited Appeal) Pgs 1 & 3; • 21.Appeal Acknowledgement Letter (Standard Appeal) Pg 1.	☐ Met ☒ Partially Met ☐ Not Met

Standard X—Grievance and Appeal Systems (42 CFR §438.228)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
HSAG Findings: CHA's *Grievance and Appeal System* policy stated that the CCO is to send an acknowledgment letter to members within five days for non-expedited appeals, and acknowledge expedited appeals orally and in writing within one business day. However, the record review revealed that the CCO did not provide oral acknowledgment within one business day for expedited appeals. The requirement was *Partially Met*.		
Required Actions: The CCO must acknowledge expedited appeals orally and in writing within one business day of receipt.		
16. The CCO's appeal process must provide: a. That the CCO may have only one level of appeal for members (or providers acting on their behalf). b. The member a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments. (The CCO must inform the member of the limited time available for this sufficiently in advance of the resolution time frame in the case of expedited resolution.) c. The member and his or her representative the member's case file, including medical records, other documents and records, and any new or additional documents considered, relied upon, or generated by the CCO in connection with the appeal. This information must be provided free of charge and sufficiently in advance of the appeal resolution time frame. d. That adjudication of appeals in a member grievance and appeals process may not be delegated to a subcontractor. e. That included, as parties to the appeal, are: i. The member and his or her representative; ii. The provider acting on the behalf of a member, with written consent from the member; iii. The CCO; and iv. The legal representative of a deceased member's estate.	**Suggested Documents:** • Grievance and appeal policies and procedures • Member handbook • Provider materials, such as provider manual *HSAG will also review compliance through file reviews. **Documents Submitted for Desk Review:** • 0.Grievance System Binder 2022, Pg 1 sections 2.1; Pg 17, sections 2.3, 2.6, 3.5, 3.6; Pg 18 sections, 3.6.1, 3.6.1.1, 3.6.2, 3.6.2.1, 3.6.2.2, 3.6.2.3 • Provider Manual_Feb 2022_Standard X (Pgs. 32-36).	☒ Met ☐ Partially Met ☐ Not Met

Standard X—Grievance and Appeal Systems (42 CFR §438.228)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
42 CFR §438.402(b);438.406(b)(4-6) *Contract: Exhibit I (1)(e)(11)* *OAR:410-141-3890(2);(7)* *OAR 410-141-3875 (14)*		
HSAG Findings: This requirement was *Met*.		
Required Actions: None.		
17. The CCO maintains an expedited review process for appeals when the CCO determines or the provider indicates that taking the time for a standard resolution could seriously jeopardize the member's life; physical or mental health; or ability to attain, maintain, or regain maximum function. The CCO's expedited review process includes: a. The CCO ensures that punitive action is not taken against a provider who requests an expedited resolution or supports a member's appeal. b. If the CCO denies a request for expedited resolution of an appeal, it must: i. Transfer the appeal to the time frame for standard resolution. ii. Make reasonable efforts to give the member prompt oral notice of the denial to expedite the resolution (including as necessary multiple calls at different times of day) iii. Follow up within two calendar days with a written notice of the denial of expedition and inform the member of the right to file a grievance if he or she disagrees with the decision to deny an expedited resolution. *42 CFR §438.410* *Contract: Exhibit I (4)(b)(3)*	**Suggested Documents:** • Grievance and appeal policies and procedures • Member handbook • Provider materials, such as provider manual • Staff training materials *HSAG will also review compliance through file reviews. **Documents Submitted for Desk Review:** • 0.Grievance System Binder 2022, Pg 2 section 3.1; Pg 19 section 3.6.9. 3.6.9.1, 3.6.9.2, Pg 20 section, 3.6.10.3, 3.6.10.4, 3.6.10.8, 3.6.10.8.1. Pg 21 section 3.6.10.8.2 • 8.Member Handbook 2022: Appeals and Hearings, Pg 55 • Provider Manual_Feb 2022_Standard X (Pgs. 32-36). • 3.CAC Board Appeal Grievance & Hearing Training Power Point 11.15.22, Slide 7;	☒ Met ☐ Partially Met ☐ Not Met

Standard X—Grievance and Appeal Systems (42 CFR §438.228)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
OAR 410-141-3895(2)(6)	• 20.Case Summary (Expedited Appeal) Pgs 1 & 3	
HSAG Findings: This requirement was *Met*.		
Required Actions: None.		
18. The CCO must resolve each appeal and provide written notice of the disposition, as expeditiously as the member's health condition requires, but not to exceed the following time frames: a. For standard resolution of appeals, within 16 days from the day the CCO receives the appeal. b. For expedited resolution, within 72 hours after the CCO receives the appeal. c. For notice of expedited resolution, the CCO must make reasonable efforts to provide oral notice of resolution. d. Written notice of appeal resolution must be in a format approved by OHA and written in language that at a minimum, meets the standards described 42 CFR §438.10. *42 CFR §438.408(b)(2); (3); (d)(2)* *Contract: Exhibit I (4)(b)* *OAR 410-141-3890(3)*	**Suggested Documents:** • Grievance and appeal policies and procedures • Member handbook • Provider materials, such as provider manual • Staff training materials *HSAG will also review compliance through file reviews. **Documents Submitted for Desk Review:** • 0.Grievance System Binder 2022 Pg 18 sections 3.6.6; Pg 20 sections 3.6.10.2, 3.6.10.2.1, 3.6.10.4 • 8.Member Handbook 2022: Appeals and Hearings, Pg 54 & 55 • 5.CHA Staff Appeal & Grievance Training Power Point 5/6/22, Appeals & Reconsiderations on Slide 11. • 4.CHA Provider Training Appeal,Grievance,Recons Power Point 11/22, Grievances and Appeals Slide 3. • 3.CAC Board Appeal Grievance & Hearing Training Power Point 11.15.22, Slide 7.	☐ Met ☒ Partially Met ☐ Not Met

Standard X—Grievance and Appeal Systems (42 CFR §438.228)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	• 21.Appeal Acknowledgement Letter, Pg 1; • 20.Case Summary (Expedited Appeal) Pgs 1 & 3 • Provider Manual_Feb 2022_Standard X (Pgs. 32-36)	
HSAG Findings: CHA's *Grievance and Appeal System* policy stated that CCO is to resolve each appeal and send written notice of the disposition as expeditiously as the member's health condition requires. The policy also stated that the CCO is to resolve standard appeals within 16 days from the day it received the appeal, and resolve expedited appeals in 72 hours from the date it received the appeal. The policy also stated that the CCO must make reasonable efforts to provide oral notice of resolution to the members or their representatives. Additionally, the policy stated that the CCO is to ensure the Appeal Resolution letter is in the format approved by OHA and written in language the members understand. The member handbook and provider manual discussed the resolution time frames. However, the record review demonstrated that the CCO did not always make efforts to provide oral notice of resolution for expedited appeals and resolution letters that were above the required sixth-grade reading level. The requirement was *Partially Met*.		
Required Actions: For notice of expedited resolution, the CCO must make reasonable efforts to provide oral notice of resolution. Additionally, written notice of appeal resolution must be in a format approved by OHA and written in language that, at a minimum, meets the standards described in 42 CFR §438.10.		
19. The CCO may extend the time frames for resolution of grievances or appeals by up to 14 calendar days if: a. The member requests the extension; or b. The CCO shows (to the satisfaction of the State, upon request) that there is need for additional information and how the delay is in the member's interest. c. If the CCO extends the time frames for resolution of grievances or appeals, it must—for any extension not requested by the member: i. Make reasonable efforts to give the member prompt oral notice of the delay (including as necessary multiple calls at different times of day).	**Suggested Documents:** • Grievance and appeal policies and procedures • Member handbook • Provider materials, such as provider manual • Staff training materials *HSAG will also review compliance through file reviews. **Documents Submitted for Desk Review:** • 0.Grievance System Binder 2022,	☒ Met ☐ Partially Met ☐ Not Met

Standard X—Grievance and Appeal Systems (42 CFR §438.228)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
ii. Within two calendar days, give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if he or she disagrees with that decision. iii. Resolve the appeal as expeditiously as the member's health condition requires and no later than the date on which the extension expires (14 calendar days following the expiration of the original appeal resolution time frame). d. If the CCO fails to adhere to the notice and timing requirements for extension of the appeal resolution time frame, the member is deemed to have exhausted the appeal process and may request a Contested case hearing. *42 CFR §438.408(c)* *Contract: Exhibit I (4)(b)(2-3)* *OAR 410-141-3890 (3)(a);(b);(c)*	Pg 12 sections 3.4.6, 3.4.6.1, 3.4.6.2, 3.4.7, 3.4.7.1 – 3.4.7.4, Page 19 sections , 3.6.8, 3.6.8.1, 3.6.8.2, 3.6.9, 3.6.9.1, 3.6.9.2, Pg 20 sections 3.6.9.3, 3.6.9.4. • 8.Member Handbook 2022: Appeals and Hearings, Pg 54 • Provider Manual_Feb 2022_Standard X (Pgs. 32-36). • 16.2021 NOABD Packet Template Approved Pg 2. • 17.NOABD Non Claims 2022 Appr Feb 2023 (This is our 2022 Template that OHA approved 1/2023), Pg 4 & 5.	
HSAG Findings: This requirement was *Met.*		
Required Actions: None.		

Standard X—Grievance and Appeal Systems (42 CFR §438.228)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
20. Appeal resolution notices must be in writing, meet the language and format requirements of §438.10, and must include: a. The results of the resolution process and the date it was completed. b. For appeals not resolved wholly in favor of the member: i. How to request the continued services. ii. Reasons for the resolution and a reference to the particular sections of the statutes and rules involved for each reason identified in the Notice of Appeal Resolution relied upon to deny the Appeal. iii. The right of the Member to request a standard or expedited Contested Case Hearing with OHA within 120 days from the date of CCO's Notice of Appeal Resolution and how to do so, which includes sending the Notice of Hearing Rights (DMAP 3030) available at https://sharedsystems.dhsoha.state.or.us/forms/ and the Hearing Request Form (MSC 0443) or Appeal and Hearing Request (OHP 3302) available on the OHA Website at: https://www.oregon.gov/oha/HSD/OHP/Pages/Forms.aspx. iv. Explanation to the member that an expedited Hearing will not be granted for post-service denials; v. The right to continue to receive benefits pending a Contested Case Hearing and how to do so; vi. Information explaining that if CCO's Adverse Benefit Determination is upheld in a Contested Case	**Suggested Documents:** • Notice of appeal resolution template • Grievance and appeal policies and procedures *HSAG will also review compliance through file reviews. **Documents Submitted for Desk Review:** • 16.2021 NOABD Packet Template Approved, Pg 2; • 17.NOABD Non Claims 2022 Appr Feb 2023 (This is our 2022 Template that OHA approved 1/2023), Pg 5. • 0.Grievance System Binder 2022, Pgs 18 & 19 sections 3.6.6, 3.6.6.1, 3.6.6.2, 3.6.6.3, 3.6.6.4, 3.6.6.4.1 - 3.6.6.4.4, 3.6.6.7, 3.6.6.7.1 - 3.6.6.7.3 Pg 25 sections, 3.1.2, 3.1.2.1,	☐ Met ☒ Partially Met ☐ Not Met

Standard X—Grievance and Appeal Systems (42 CFR §438.228)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
Hearing, the member may be liable for the cost of any continued benefits. *Note: Continuation of benefits/services applies only to previously authorized services for which the CCO provides 10-day advance notice to terminate, suspend, or reduce the services.* *42 CFR §438.408(e)* *Contract: Exhibit I (4)(b)(4)* *OAR 410-141-3890 (11)*		
HSAG Findings: CHA's *Grievance and Appeal System* policy stated that appeal resolution notices are to notify members of all components listed in this element except component (b)(iv). Additionally, the component was not included in the records reviewed. Although this requirement was missing from the template and not met for the 2023 review, at the direction of OHA, written notice requirements provided in the template from or at the direction of OHA will not be captured in the scoring for the 2023 compliance review. However, other unmet requirements, such as policy omissions, led to the findings for this review. This requirement was *Partially Met.*		
Required Actions: The CCO must revise applicable policies to state appeal resolution notices will include an explanation to members that an expedited hearing will not be granted for post-service denials.		
Recommendations: HSAG recommends that the CCO review the most recent versions of its templates to ensure minimum federal and State requirements are captured; any omissions in the template should be discussed with OHA and will be assessed during the following compliance review for this standard. The CCO should also ensure that it implements the appropriate version of the template.		
21. The member may request a Contested case hearing after receiving notice that the CCO is upholding the adverse benefit determination, within 120 calendar days from the date of the notice of appeal resolution. a. The parties to the Contested case hearing include the CCO, as well as the member and his or her representative or the representative of a deceased member's estate. *42 CFR §438.408(f)(1)–(3)* *Contract: Exhibit I (5)* *OAR 410-141-3890 (7)* *OAR 410-141-3900 (1)(b);(2)(a)*	**Suggested Documents:** • Grievance and appeal policies and procedures • Contested case hearing policies and procedures • Member handbook • Provider materials, such as provider manual • Staff training materials **Documents Submitted for Desk Review:**	☒ Met ☐ Partially Met ☐ Not Met

Standard X—Grievance and Appeal Systems (42 CFR §438.228)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	• 0.Grievance System Binder 2022 Pg 25 sections 3.1, 3.1.1.1, 3.1.2.1, Pg 26 sections 3.4, 3.4.1, 3.4.2, • 8.Member Handbook 2022: Appeals and Hearings, Pg 55 • 4.CHA Provider Training Appeal,Grievance,Recons Power Point 11/22, Grievances and Appeals Slide 4; • 3.CAC Board Appeal Grievance & Hearing Training Power Point 11.15.22, Slide 8. • Provider Manual_Feb 2022_Standard X Pgs 33	
HSAG Findings: This requirement was *Met*.		
Required Actions: None.		
22. The CCO provides for continuation of benefits/services while the CCO-level appeal and the Contested case hearing are pending if: a. The member files in a timely manner* for continuation of benefits—defined as on or before the later of the following: i. Within 10 days of the CCO mailing the notice of adverse benefit determination. ii. The intended effective date of the proposed adverse benefit determination. b. The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment. c. The services were ordered by an authorized provider. d. The period covered by the original authorization has not expired.	**Suggested Documents:** • Grievance and appeal policies and procedures • Staff training materials • *HSAG will also review compliance through file reviews. **Documents Submitted for Desk Review:** • 0.Grievance System Binder 2022, Pg 21 sections 3.6.11, 3.6.12, 3.6.12.1, 3.6.12.2, 3.6.12.3, 3.6.12.4, 3.6.12.5. Pg 27 Sections 3.6.6, 3.6.6.1, 3.6.6.3.2, 3.6.6.3.3, 3.6.6.3.4, 3.6.6.3.5	☒ Met ☐ Partially Met ☐ Not Met

Standard X—Grievance and Appeal Systems (42 CFR §438.228)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
e. The member requests an appeal within 60 days following the adverse benefit determination. *Note: This definition of "timely filing" only applies for this scenario—i.e., when the member requests continuation of benefits for previously authorized services proposed to be terminated, suspended, or reduced.* *Note: The provider may not request continuation of benefits on behalf of the member (page 27510, 2016 Federal Register).* *42 CFR §438.420(a);(b)* *Contract: Exhibit I (6)* *OAR 410-141-3910 (1)*	• 5.CHA Staff Appeal & Grievance Training Power Point 5/6/22, Appeals & Reconsiderations on Slide 11. • 3.CAC Board Appeal Grievance & Hearing Training Power Point 11.15.22, Slide 8. • 4.CHA Provider Training Appeal, Grievance,Recons Power Point 11/22, Grievances and Appeals Slide 4; • 22.Appeal COB Denied Untimely	
HSAG Findings: This requirement was *Met*.		
Required Actions: None.		
23. If, at the member's request, the CCO continues or reinstates the benefits while the appeal or contested case hearing is pending, the benefits must be continued until one of the following occurs: a. The member withdraws the appeal or request for a contested case hearing. b. The member does not request a contested case hearing and continuation of benefits within 10 days from when the CCO mails the notice of appeal resolution. c. A contested case hearing officer issues a hearing decision adverse to the member. *42 CFR §438.420(c)* *Contract: Exhibit I (6)(c)* *OAR 410-141-3910 (1)(d)*	**Suggested Documents:** • Grievance and appeal policies and procedures • Contested case hearing policies and procedures **Documents Submitted for Desk Review:** • 0.Grievance System Binder 2022, • Page 22 section 3.6.12.6.2, 3.6.12.6.3, Pg 21, 3.6.12.6.4, 3.6.12.6.5, • Pg 28 section 3.6.6.4.1, 3.6.6.4.2, 3.6.6.4.3, 3.6.6.4.4 • 22.Appeal COB Denied Untimely	☒ Met ☐ Partially Met ☐ Not Met
HSAG Findings: This requirement was *Met*.		
Required Actions: None.		

Standard X—Grievance and Appeal Systems (42 CFR §438.228)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
24. Member responsibility for services furnished while the appeal or contested case hearing is pending: a. If the final resolution of the appeal is adverse to the member, that is, upholds the CCO's adverse benefit determination, the CCO may recover the cost of the services furnished to the member while the appeal is pending, to the extent that they were furnished solely because of the requirements of this section. *42 CFR §438.420(d)* *Contract: Exhibit I (6)(d)* *OAR: 410-141-3910(1)(e)*	**Suggested Documents:** • Grievance and appeal policies and procedures • Contested case hearing policies and procedures • Member handbook **Documents Submitted for Desk Review:** • 0.Grievance System Binder 2022, Pg 21 sections 3.6.11.4, Pg 21; Pg 28 sections 3.6.6.5 • 8.Member Handbook 2022: Appeals and Hearings, Pg 55	☒ Met ☐ Partially Met ☐ Not Met
HSAG Findings: This requirement was *Met*.		
Required Actions: None.		
25. Effectuation of reversed appeal resolutions: a. If the CCO or the Contested case hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the CCO or officer must authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires but no later than 72 hours from the date it receives notice reversing the determination. b. If the CCO or the Contested case hearing officer reverses a decision to deny authorization of services, and the member received the disputed services while the appeal was pending, the CCO must pay for those services, in accordance with State policy and regulations.	**Suggested Documents:** • Grievance and appeal policies and procedures • Contested case hearing policies and procedures • Contested case tracking reports *HSAG will also review compliance through file reviews. **Documents Submitted for Desk Review:** • 0.Grievance System Binder 2022,	☒ Met ☐ Partially Met ☐ Not Met

Standard X—Grievance and Appeal Systems (42 CFR §438.228)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
42 CFR §438.424 *Contract: Exhibit I (7)* *OAR: 410-141-3910(2)*	Pg 22 sections 3.6.12.6.5.1.1, 3.6.12.6.5.1.2, 3.6.12.6.5.1.3, 3.6.12.6.5.1.4, Pg 28 sections 3.6.8, 3.6.9 • 23.Hearings Log 2022	
HSAG Findings: This requirement was *Met*.		
Required Actions: None.		
26. The CCO maintains records of all grievances and appeals. The records must be accurately maintained in a manner accessible to the State and available on request to CMS. The record of each grievance and appeal must contain, at a minimum, all of the following information: a. A general description of the reason for the appeal or grievance and the supporting reasoning for its resolution; b. The member's name and ID; c. The date CCO received the grievance or appeal filed by the member, subcontractor, or provider; d. The NOABD; e. If filed in writing, the appeal or grievance; f. If filed orally, documentation that the grievance or appeal was received orally; g. Records of the review or investigation at each level of the appeal, grievance, or contested case hearing; h. Notice of resolution of the grievance or appeal, including dates of resolution at each level; i. Copies of correspondence with the member and all evidence, testimony, or additional documentation provided by the member, the member's representative, or	**Suggested Documents:** • Grievance and appeal policies and procedures • Grievance and appeal tracking reports *HSAG will also review compliance through file reviews. **Documents Submitted for Desk Review:** • 0.Grievance System Binder 2022, Pg 14 sections 4.2.4, Pg 14, 4.2.4.7, 4.2.4.1, 4.2.4.2, 4.2.4.3, 4.2.4.5, 4.2.4.6, 4.2.4.7, 4.2.4.8, 4.2.4.9, Pg 23 sections 4.2.7, 4.2.7.1, 4.2.7.2, 4.2.7.3, 4.2.7.4, 4.2.7.5, 4.2.7.6, 4.2.7.7, 4.2.7.8, 4.2.7.9, 4.2.7.10 • 7.Q3 2022 Grievance and Appeals Exhibit I	☐ Met ☒ Partially Met ☐ Not Met

Standard X—Grievance and Appeal Systems (42 CFR §438.228)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
the member's provider as part of the grievance, appeal, or contested case hearing process; and j. All written decisions and copies of all correspondence with all parties to the grievance, appeal, or contested case hearing. k. Resolution at each level of the appeal or grievance process, as applicable. l. Date of resolution at each level of the appeal or grievance process, as applicable. *42 CFR §438.416* *Contract: Exhibit I (9)(b)* *OAR 410-141-3915*		
HSAG Findings: CHA's *Grievance and Appeal System* policy asserted that the CCO is to comply with all components of this element except (i), all evidence, testimony, or additional documentation provided by the members, the members' representatives, or the members' providers as part of the grievance, appeal, or contested case hearing process. The requirement was *Partially Met*.		
Required Actions: The CCO must revise its policy and ensure that it maintains records of all grievances and appeals that include all evidence, testimony, or additional documentation provided by the members, the members' representatives, or the members' providers as part of the grievance, appeal, or contested case hearing process.		
27. The CCO provides the information about the grievance, appeal, and contested case hearing system to all providers and subcontractors at the time they enter into a contract. The information includes: a. The member's right to file grievances and appeals. b. The requirements and time frames for filing grievances and appeals. c. The right to a Contested case hearing after the CCO has made a decision on an appeal which is adverse to the member. d. The availability of assistance in the filing processes.	**Suggested Documents:** • Grievance and Appeal policies and procedures • Provider agreement • Provider materials, such as provider manual • Subcontractor Contract **Documents Submitted for Desk Review:** • 0.Grievance System Binder 2022, Page 5 sections 5.2.2, 5.2.2.1, 5.2.3, 5.2.3.1,	☐ Met ☒ Partially Met ☐ Not Met

Standard X—Grievance and Appeal Systems (42 CFR §438.228)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
e. The fact that, when requested by the member: f. Services that the CCO seeks to reduce or terminate will continue if the appeal or request for Contested case hearing is filed within the time frames specified for filing. g. The member may be required to pay the cost of services furnished while the appeal or Contested case hearing is pending, if the final decision is adverse to the member. h. Written notification of updates to these procedures and timeframes **within 5 business days** after approval of such updates by OHA. *42 CFR §438.414* *Contract: Exhibit I (1)(b)*	Page 6 sections 5.2.3.2, 5.2.3.3, 5.2.3.3.2, 5.2.3.4, 5.2.3.7.1, 5.2.3.7.2, Pg 6. • Provider Manual_Feb 2022_Standard X Pgs. 33 • CHA Rogue Valley Surgery Center Agreement (Pg. 13 Section 8.2).	
HSAG Findings: CHA's *Grievance and Appeal System* policy appropriately addressed that providers and subcontractors are to be advised of member rights, timelines, and processes related to grievances, appeals, contested case hearings, and NOABDs when they sign a contract with CHA. The CCO provided its Rogue Valley Surgical Center Agreement, which included language that stated the CCO maintained grievance policies and procedures. Additionally, the CCO provided screenshots of its Valera Health contract that included similar language. However, the contract sections did not provide the required information regarding the grievance, appeal, and contested case hearing system outlined in the requirements at (a)-(f). The requirement was *Partially Met*.		
Required Actions: The CCO must provide participating providers and subcontractors when they enter into a subcontract written notification of procedures and time frames for grievances, notice of adverse benefit determination, appeals, and contested case hearings as outlined in Ex. I of the CCO contract. This notification must include the information outlined in elements a through f. The CCO also must provide written notification of updates to these procedures and time frames within five business days after OHA approval of such updates. Evidence of providing the appropriate information could include: • Attachments, supplemental documentation, or emails provided to subcontractors and providers at the time of contracting. • Evidence of providing the provider manual during the onboarding process. • Evidence of providing any updates to the procedures and time frames within five business days after OHA approval. • Detailed processes/procedures that outline how the information is provided.		

Results for Standard X—Grievance and Appeal Systems							
Total	Met	=	17	X	1.0	=	17.0
	Partially Met	=	10	X	0.5	=	5.0
	Not Met	=	0	X	0.0	=	0.0
Total Applicable		=	27	**Total Score**		=	22.0

Total Score ÷ Total Applicable	=	**81.5%**

Standard XIV—Member Information

Standard XIV—Member Information (42 CFR §438.10)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
1. The CCO provides all required member information to members in a manner and format that may be easily understood (6th grade reading level) and is readily accessible by members. *Note: Readily accessible means electronic information which complies with 508 guidelines, Section 504 of the Rehabilitation Act, and W3C's Web Content Accessibility Guidelines.* *42 CFR §438.10(c)(1)* *Contract: Exhibit B Part 3 (4)(d)(4);(6)* *OAR 410-141-3585 (2)*	**Suggested Documents:** • Policies and procedures on member materials and dissemination of information to members • (HSAG will evaluate the reading level of letters, handbooks, and other materials submitted for requirements throughout this standard.) **Documents Submitted for Desk Review:** • Document.Review.PP11002 (pg 1 sections 3.2-3.3.1, 4.2, 4.2.1.1) • CHA.Member.Handbook.202204, (pg. 2) • 0.Grievance and Appeal System Binder 2022, (3.2 Pg 2)	☒ Met ☐ Partially Met ☐ Not Met
HSAG Findings: This requirement was *Met*.		
Required Actions: None.		
2. The CCO has in place a mechanism to help members understand the requirements and benefits of the plan. *42 CFR §438.10(c)(7)* *Contract: Exhibit B Part 3 (2)(f)* *OAR 410-141-3585(3)*	**Suggested Documents:** • Policies and procedures on member materials and dissemination of information to members • Internal protocols/training materials for staff • Member-facing communications **Documents Submitted for Desk Review:**	☒ Met ☐ Partially Met ☐ Not Met

Standard XIV—Member Information (42 CFR §438.10)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	• CHA.Member.Handbook.202204, (pg. 9-11, 14-24, 34-36, 38-39) • Member Experience New Member Pack Process (pg. 1 section 1.1, 3.1-3.1.1.5) • Dissemination.of.Information.PP07011 (pg. 2 section 4.1.1-4.1.1.3.1, 4.6) • CHA website link: https://www.cascadehealthalliance.com/for-members/member-benefits/ • Covered Benefits Flyer English	
HSAG Findings: This requirement was *Met*.		
Required Actions: None.		
3. For consistency in the information provided to members, the CCO uses the following as developed by the State: a. Definitions for managed care terminology, including appeal, copayment, durable medical equipment, emergency medical condition, emergency medical transportation, emergency room care, emergency services, excluded services, grievance, habilitation services and devices, health insurance, home healthcare, hospice services, hospitalization, hospital outpatient care, medically necessary, network, nonparticipating provider, participating provider, physician services, plan, preauthorization, premium, prescription drug coverage, prescription drugs, primary care physician, primary care provider, provider, rehabilitation services and devices, skilled nursing care, specialist, and urgent care. b. Model member handbooks and member notices.	**Suggested Documents:** • Policies and procedures on member materials and dissemination of information to members • Member handbook • Training or other materials that include definitions • (HSAG will assess policies and procedures submitted throughout.) **Documents Submitted for Desk Review:** • CMS 2390 Information Requirements • CHA.Member.Handbook.202204 (pg. 63-64)	☒ Met ☐ Partially Met ☐ Not Met

Standard XIV—Member Information (42 CFR §438.10)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
42 CFR §438.10(c)(4) *Contract: Exhibit A; Exhibit B Part 3 (5)(a)*		
HSAG Findings: This requirement was *Met*.		
Required Actions: None.		
4. The CCO makes written materials that are critical to obtaining services available in prevalent non-English languages in its service area and in alternative formats upon member request at no cost. a. Written materials that are critical to obtaining services include provider directories, member handbooks, welcome letters, appeal and grievance notices, and denial and termination notices. b. All written materials for members must: i. Use a font size no smaller than 12 point. ii. Be available in alternative formats and through provision of auxiliary aids and service that takes into consideration the special needs of members with disabilities or limited English proficiency. iii. Include taglines for written materials critical to obtaining services printed in a conspicuously visible (18-point) font size and prevalent non-English languages explaining the availability of written translations or oral interpretation to understand the information provided, information on how to request auxiliary aids and services, and the toll-free and TTY/TDD of the CCO's customer service number. *42 CFR §438.10(d)(3);(6)* *Contract: Exhibit B Part 3 (4)(d)* *OAR 410-141-3585 (5)(a-b)*	**Suggested Documents:** • Policies and procedures on member materials and dissemination of information to members • Interpretation/translation/alternate format/communication policies and procedures • Methodology for providing copies of translated member handbooks to members • Member marketing materials • Examples of materials available in the prevalent non-English language (Spanish). • (HSAG will assess materials submitted throughout this standard.) **Documents Submitted for Desk Review:** • Alternate.Format.And.Language.Access.Services.PP13002 • CHA.Member.Handbook.202204 (pg. 2-6) • Document.Review.PP11002 pg 2 sections 4.2-4.2.1.1	☒ Met ☐ Partially Met ☐ Not Met

Standard XIV—Member Information (42 CFR §438.10)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	• 0.Grievance and Appeal System Binder 2022, Pg 2 sections 3.2, 3.3, 3.3.1, 3.3.2, 3.3.2.1 • 1.Claims NOADB Feb 2023 Spanish doc (example). • Cascade Health Alliance letter SPANISH • 1.Claims NOABD Feb 2023_Spanish • 2.NOABD Non Claims Feb 2023_Spanish • 3.NOAR Feb 2023_Spanish • 4.Appeal Ack Feb 2023_Spanish • 5.Appeal Extension Notice Feb 2023_Spanish • 6.Appeal Dismissal Feb 2023_Spanish • 7.Grievance Dismissal Feb 2023_Spanish • 8.CHA.Member.Handbook.202204 • 9.Expedited Appeal Determination Feb 2023_Spanish • 10.Withdrawal of Appeal Feb 2023_Spanish • 11.Grievance Ack Feb 2023_Spanish • 12.Grievance Ack & Resolution Feb 2023_Spanish • 13.Grievance Resolution Feb 2023_Spanish • 14.Grievance Withdrawal Feb 2023_Spanish • 15.Grievance Filed By Other Dismissal Feb 2023_Spanish • CHA-Complaint-Form-1-2023_Spanish	

Standard XIV—Member Information (42 CFR §438.10)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	• Nondiscrimination Statement Notice 1.2023_spaFinal • CMS 2390 Information Requirements	
HSAG Findings: This requirement was *Met*.		
Required Actions: None.		
5. If the CCO makes information available electronically—Information provided electronically must meet the following requirements: a. The format is readily accessible (see definition of readily accessible above). b. The information is placed in a website location that is prominent and readily accessible. c. The information can be electronically retained and printed. d. The information complies with content and language requirements. e. The member is informed that the information is available in paper form without charge upon request and is provided within five business days. *42 CFR §438.10(c)(6)* *Contract: Exhibit B Part 3 (4)(d)(6)* *OAR 410-141-3585 (5)(c)*	**Suggested Documents:** • Policies and procedures on member materials and dissemination of information to members • If the requirement for providing the handbook or provider directory is met through availability of the materials in an electronic format, submit an example of how members are notified how to access the materials electronically (welcome letter, etc.) • Example of how members are informed that materials accessed electronically are available in paper form within five business days. • Policies and procedures on dissemination of information to members • Sample member communications **Documents Submitted for Desk Review:** • https://www.cascadehealthalliance.com/for-members/member-handbook-downloads/ • https://www.cascadehealthalliance.com/for-members/member-handbook-downloads/	☐ Met ☒ Partially Met ☐ Not Met

Standard XIV—Member Information (42 CFR §438.10)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	• Member Experience New Member Pack Process (pg. 1 section 1.1, 3.1-3.1.1.5) • CHA.Member.Handbook.202204 (pg. 8, 62) • Dissemination.of.Information.PP07011 (pg. 1 section 3.1, 4.6) • OHP-CHA-19-090_Welcome.Letter.	
HSAG Findings: The *Dissemination of Information* policy offered a high-level statement that one of the methods by which CHA is to provide information to members is via its website. The CCO's website offered PDF versions of the member handbook and provider directory, which could be downloaded and printed, as well as information indicating that member handbooks were available in paper form without charge upon request and would be provided within five business days. The CCO tracked the timeliness of the provision of paper documents via its Essette member tracking system and submitted supporting documentation following the site visit. However, during the site visit, CCO staff did not articulate a process, nor did a documented process exist for ensuring that information supplied to members electronically was compliant with 508 guidelines, Section 504 of the Rehabilitation Act, and W3C's Web Content Accessibility Guidelines. This requirement was *Partially Met*.		
Required Actions: The CCO must develop a process for ensuring that information supplied to members electronically is compliant with 508 guidelines, Section 504 of the Rehabilitation Act, and W3C's Web Content Accessibility Guidelines.		
6. The MCE makes the following pharmacy information available to its members in electronic or paper form: a. Which medications are covered (both generic and name brand). b. What tier each medication is on. c. The formulary drug list must be available on the MCE's website in a machine-readable file and format as specified by the Secretary of Health and Human Services. *45 CFR §180.20 defines "machine-readable" format as a digital representation of data or information in a file that can be imported or read into a computer system for further processing. Examples of machine-readable formats include, but are not limited to, XML, JSON, and CSV formats.* *42 CFR §438.10 (h)(4)(i)*	**Suggested Documents:** • Policies and procedures on member materials and dissemination of information to members • Link to Formulary List, including machine-readable • CCO website address **Documents Submitted for Desk Review:** • Standard XV Element 6 2022 Formulary • CHA website link: https://www.cascadehealthalliance.com/for-	☐ Met ☒ Partially Met ☐ Not Met

Standard XIV—Member Information (42 CFR §438.10)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
Exhibit B, Part 2 (7)(e)(7) *OAR 410-141-3585(7)*	members/member-benefits/covered-medications/	
HSAG Findings: The CCO did not provide a policy or process for developing and maintaining its formulary. The foreword of the formulary document indicated that it was developed by the CHA Pharmacy & Therapeutics Committee and administered by the CCO's pharmacy benefit manager MedImpact and was not compliant with either the requirement or the CCO's *Document Review* policy. During the site visit, CCO staff did not articulate a process for reviewing the formulary for compliance as a member-facing document. The formulary was written for a provider audience rather than a member audience; used fonts smaller than 12-point; contained no large-font taglines for the availability of assistance, printing, or translation; and did not meet readability standards. The formulary listed which medications were covered (generic and name-brand) but did not indicate the tier of any medication, instead displaying from one to four U.S. dollar symbols beside each item and an explanation that this indicated "least expensive" to "most expensive." Additionally, although the formulary was available in a PDF format, it was not available in a machine-readable format as defined by 45 CFR §180.20 (e.g., Extensible Markup Language [XML], JavaScript Object Notation [JSON]). This requirement was *Partially Met*.		
Required Actions: The CCO must ensure that the electronic and paper form formulary made available to members meets all readability standards and formatting requirements; includes large font (at least 18-point) taglines for availability of assistance, printing, and translation; includes the tiers of each medication; and is also made available on the CCO's website in a machine-readable format as defined by 45 CFR §180.20.		
7. The CCO makes interpretation services (for all non-English languages) available free of charge and notifies members that oral interpretation is available for any language and written translation is available in prevalent languages, and how to access these services. a. This includes oral interpretation and use of auxiliary aids such as TTY/TDD and American Sign Language. b. The CCO notifies members that auxiliary aids and services are available upon request and at no cost for members with disabilities, and how to access them. *42 CFR §438.10(d)(4-5)* *Contract: Exhibit B Part 3 (4)(d)(3)* *OAR 410-141-3585 (10)*	**Suggested Documents:** • Policies and procedures on member materials and dissemination of information to members • Member handbook • Interpretation/translation/alternate format/communication policies and procedures **Documents Submitted for Desk Review:** • Member Handbook, (pg. 2, 7, 10, 19, 33, 47, 53)	☒ Met ☐ Partially Met ☐ Not Met

Standard XIV—Member Information (42 CFR §438.10)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	• Alternate.Format.And.Language.Access.Services.PP13002 page 1 section 1.5, 4.1.1-4.1.3	
HSAG Findings: This requirement was *Met*.		
Required Actions: None.		
8. The CCO must make a good faith effort to give written notice of termination of a contracted provider within 15 calendar days after the receipt or issuance of the termination notice or 30 calendar days prior to the effective date of the termination, whichever is later, to each member who received his or her primary care from, or was seen on a regular basis by, the terminated provider. *42 CFR §438.10(f)(1)* *OAR 410-141-3585(13)(f)*	**Suggested Documents:** • Policies and procedures on member materials and dissemination of information to members • Redacted example letter • Template letter **Documents Submitted for Desk Review:** • Provider.Dismissal.of.Member.Binder.PP13008	☐ Met ☐ Partially Met ☒ Not Met
HSAG Findings: The CCO did not have a policy or process that addressed the requirement to provide written notice to members of the termination of a contracted provider, nor did CCO staff articulate such a process during the site visit. During the site visit, CCO staff stated that in cases wherein a provider terminates, member communication would be handled by group provider practices and did not indicate that the CCO conducted oversight or coordination of communication with the member. This did not meet the intent of the requirement for the CCO to take a leading or at least oversight role in such communications. Additionally, there was no indication of timeliness tracking for such communications. This requirement was *Not Met*.		
Required Actions: The CCO must have a process for and document efforts to give written notice of termination of a contracted provider within 15 calendar days after the receipt or issuance of the termination notice or 30 calendar days prior to the effective date of the termination, whichever is later, to each member who received his or her primary care from, or was seen regularly by, the terminated provider. The CCO must track the timeliness of providing the appropriate information to the member.		

Standard XIV—Member Information (42 CFR §438.10)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
9. The CCO must make available, upon request, within five business days, additional information that the CCO has created that has been pre-approved by OHA and is otherwise available, including information on the CCO's structure and operations, and any physician incentive plans in place as set forth in §438.3. *42 CFR §438.10(f)(3)* *Contract: Exhibit B Part 3(4)(g)*	**Suggested Documents:** • Policies and procedures on member materials and dissemination of information to members • Member communication templates on incentive plans and structure/operations **Documents Submitted for Desk Review:** • Dissemination of Information PP07011 • Document.Review.PP11002	☐ Met ☐ Partially Met ☒ Not Met
HSAG Findings: The CCO did not have a policy or process that addressed the requirement to provide members with information on physician incentive plans on request, nor did CCO staff articulate such a process during the site visit. While the member handbook stated that providers were not paid to deny, limit, or discontinue services, this did not address the federal intent to provide members with information on what might limit providers in the services they offer. This requirement was *Not Met*.		
Required Actions: The CCO must have a policy or process for providing to members, within five business days of a request, information that the CCO has created which has been pre-approved by OHA and is otherwise available, including information on the CCO's structure and operations, and any physician incentive plans in place.		
10. The CCO makes available to members in paper form upon request, and electronic form, a provider directory that includes the following information about contracted network physicians (including specialists), hospitals, pharmacies, and behavioral health providers (as applicable), dentists, dental and oral health providers, NEMT providers, and LTSS providers (as appropriate): a. The provider's name and group affiliation, street address(es), telephone number(s), website URL (as appropriate), specialty (as appropriate), and whether the providers will accept new members.	**Suggested Documents:** • Policies and procedures on member materials and dissemination of information to members • Provider directory **Documents Submitted for Desk Review:** • CHA website link: https://www.cascadehealthalliance.com/for-members/find-a-provider/ • Providerdirectory08.15.2022	☐ Met ☒ Partially Met ☐ Not Met

Standard XIV—Member Information (42 CFR §438.10)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
b. The provider's cultural and linguistic capabilities, including languages (including American Sign Language) spoken by the provider or skilled medical interpreters offered by the provider or an Authority-approved qualified and, as applicable, certified health care interpreter(s) at no cost to members at the provider's office. c. Whether the provider's office has accommodations for people with physical disabilities, including offices, exam rooms, and equipment. d. Whether the provider offers both telehealth and in-person appointments; e. Availability of auxiliary aids and services for all members with disabilities upon request and at no cost; f. Whether the provider's office or facility is accessible and has accommodations for people with physical disabilities, including but not limited to information on accessibility of providers' offices, exam rooms, restrooms, and equipment. *42 CFR §438.10(h)(1)* *Contract: Exhibit B Part 3 (6)(e);(f)* *OAR 410-141-3585(6)*	• PP09002-Credentialing.Policy.01.26.22	
HSAG Findings: The CCO's Credentialing policy described a process for developing and maintaining the provider directory via the credentialing specialist staff position. The position's duties were described, including using credentialing and recredentialing information to create and maintain provider files and the provider directory, updating the directory and provider database within 30 days of receiving information, updating the printable directory by the 15th of every month, and sending the updated directory file to Member Services and IT or Web administrator for inclusion on the website. However, a review of the online and print-version directory showed multiple inconsistencies, functionality errors, instances of noncompliance, and asymmetries in available information. The electronic (i.e., online) version of the CCO's provider directory took the form of a searchable website with several filter options. Each time a user clicked on the searchable directory, a message indicated that the browser had been inactive too long, and directions were given to click a		

Standard XIV—Member Information (42 CFR §438.10)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
"start new search" button. The filter options were limited, offering options to filter by last name; gender (limited to "Male," "Female," and "No preference"); specialty; whether new patients were accepted; and provider spoken languages (listing 11 language options and "No Other Language Required"). The language options did not include American Sign Language (ASL), and a review of all providers who spoke a language other than English only returned results for six of the 11 listed options. The specialty options included physicians, multiple specialties, behavioral health, dentists, and oral health specialties. The specialty options did not include hospitals, pharmacies, or contact information for non-emergency medical transportation (NEMT). Searching the online directory for providers by last names found in the printed directory returned no results for four out of 10 random searches. During the site visit, CCO staff stated that information for the provider directory was primarily collected as part of the in-house credentialing process but did not articulate a process for validating the information within the provider directory or ensuring agreement between the printed and online versions of the provider directory. Search results for primary care providers (PCPs) accepting new patients returned a list of individual providers with information including the provider's name and group affiliation, street address, telephone number, specialty, and a link to the provider's street address in Google Maps. Provider website links were infrequently provided, and those that were provided often were listed as a "Visit our Web Site" link rather than a full-length URL address. No search results returned information regarding whether the provider's office had accommodations for people with physical disabilities, including offices, exam rooms, restrooms, and equipment, or whether the provider offered both telehealth and in-person appointments. While there was a separate list of Americans with Disabilities (ADA)-compliant providers available on the CCO's website, which offered contact information for various providers grouped by practice and specialty, the list was not searchable and instead seemed to be a "Smartsheet" exported list. The CCO's printed version of the provider directory was arranged by specialty and clinic name. It contained information about physicians, including specialists, hospitals, pharmacies, behavioral health providers, dentists, and oral health providers. It did not include contact information for NEMT scheduling (i.e., brokerage contact information). Entries for facilities included lists of provider names and specialties, group affiliation, street address, hours of operation, telephone numbers, and URL address for the facility. However, many hyperlinked URL addresses did not connect to a functioning website and instead returned an error code (i.e., error 516 upstream certificate CN [common name] mismatch). The first page of the provider directory stated that translation, interpreter, and accommodation services were free and available by calling the given phone numbers. However, no TTY number was given. Facility entries included an indicator for "known to have culturally and linguistically trained providers and staff"; indicators for whether the facility could speak Spanish; and indicators for whether individual providers could speak Spanish, German, or French. No other languages (including ASL) were indicated, and in some instances, a facility was noted as being able to speak Spanish without having any providers indicated as speaking Spanish. Indicators were given as to whether a facility was "known to be ADA compliant" but without any additional detail about available accommodations. One individual physical health provider and one behavioral health clinic in the directory were listed as offering telemedicine. This requirement was *Partially Met*.		

Standard XIV—Member Information (42 CFR §438.10)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
Required Actions: The CCO must ensure that all required informational elements within both the electronic and print versions of the provider directory are present, accurate, in agreement, and up to date. The online provider directory must include information for hospitals and pharmacies and information on how to arrange for NEMT (e.g., by listing contact information for any contracted NEMT brokerages), and must be populated with information on the availability of telehealth appointments and the accessibility status of provider locations. This accessibility information must include whether the provider's location has accommodations for people with physical disabilities, including offices, exam rooms, restrooms, and equipment. The printable provider directory must include accurate information and functioning external links.		
11. The provider directory in: a. A paper format must be updated at least: i. Monthly, if the CCO does not have a mobile-enabled, electronic directory; or ii. Quarterly, if the CCO has a mobile-enabled, electronic provider directory. b. An electronic format must be updated no later than 30 calendar days after the CCO receives updated provider information. *The term "mobile-enabled" means a mobile website or application that makes provider directory information usable for smartphone or mobile technology users. 2020 Medicaid and CHIP Final Rule Federal Register Preamble, page 72800.* *42 CFR §438.10(h)(3)* *Contract: Exhibit B Part 3(6)(g)* *OAR 410-141-3585(6)(m)*	**Suggested Documents:** • Policies and procedures for managing and updating provider directory information • PDF of hard copy provider directory • Link to online provider directory • Link to machine-readable format **Documents Submitted for Desk Review:** • CHA website link: https://www.cascadehealthalliance.com/for-members/find-a-provider/https://res.cloudinary.com/dpmykpsih/image/upload/cascade-health-site-355/media/01c23826080e464e855ab23b1c4e8745/providerdirectory030723.pdf • Providerdirectory08.15.2022	☒ Met ☐ Partially Met ☐ Not Met
HSAG Findings: This requirement was *Met*.		
Required Actions: None.		

Standard XIV—Member Information (42 CFR §438.10)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
12. Provider directories must be made available on the CCO's website in a machine-readable file and format as specified by the Secretary of Health and Human Services. *45 CFR §180.20 defines "machine-readable" format as a digital representation of data or information in a file that can be imported or read into a computer system for further processing. Examples of machine-readable formats include, but are not limited to, XML, JSON, and CSV formats.* *42 CFR §438.10(h)(4)* *Contract: Exhibit B Part 3(6)(j)* *OAR 410-141-3585 (6)(m)*	**Suggested Documents:** • Policies and procedures on member materials and dissemination of information to members • Link to the CCO's provider directory on the website **Documents Submitted for Desk Review:** • https://www.cascadehealthalliance.com/for-members/find-a-provider/https://res.cloudinary.com/dpmykpsih/image/upload/cascade-health-site-355/media/01c23826080e464e855ab23b1c4e8745/providerdirectory030723.pdf	☐ Met ☐ Partially Met ☒ Not Met
HSAG Findings: The CCO's provider directory was available for download in PDF format via its website but not in a machine-readable file and format as specified by 45 CFR §180.20 (e.g., JSON). The link provided by CHA in its submission did not yield any results. During the site visit, CCO staff did not articulate awareness of the requirement. This requirement was *Not Met*.		
Required Actions: The CCO must ensure that the provider directory is available on its website in a machine-readable file and format as specified by the Secretary of Health and Human Services and defined in 45 CFR §180.20.		
13. Within 14 days of the CCO receiving notice of a member's enrollment, MCEs shall mail a welcome packet to new members and to members returning to the CCO 12 months or more after previous enrollment. The packet shall include, at a minimum: a. A welcome letter, b. A member handbook, and	**Suggested Documents:** • Policies and procedures on member materials and dissemination of information to members • Evidence of providing member materials • Vendor tracking of timeliness **Documents Submitted for Desk Review:** • Member Experience New Member Pack Process	☒ Met ☐ Partially Met ☐ Not Met

Standard XIV—Member Information (42 CFR §438.10)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
c. Information on how to access a provider directory, including a list of any in-network retail and mail-order pharmacies. *42 CFR §438.10(g)(1)* *OAR 410-141-3585 (8)*	• OHP-CHA-19-090_Welcome.Letter • CHA.Member.Handbook.202204 • Providerdirectory08.15.2022	
HSAG Findings: This requirement was *Met*.		
Required Actions: None.		
14. For existing members, the CCO shall notify members annually of the availability of a member handbook and provider directory and how to access those materials. a. The CCO shall send hard copies upon request within five days. *Contract: Exhibit B Part 3 (5)(c)* *OAR 410-141-3585 (9)*	**Suggested Documents:** • Policies and procedures on member materials and dissemination of information to members • Evidence of providing annual notices • Evidence of tracking timeliness **Documents Submitted for Desk Review:** • Dissemination of Information PP07011 • Member Experience New Member Pack Process (pg. 1 section 3.1-3.1.1.5)	☐ Met ☐ Partially Met ☒ Not Met
HSAG Findings: The CCO did not provide a policy or process to notify existing members annually of the availability of a member handbook and provider directory and how to access those materials. During the site visit, CCO staff stated that there was no such policy. Following the site visit, the CCO provided a member benefits flyer, which encouraged members to visit the CCO's website to understand their plan benefits and also provided phone numbers and asserted the availability of free interpretation services. However, there was no specific statement regarding the availability of the member handbook or provider directory in either online or print form, or how to access those materials. This requirement was *Not Met*.		
Required Actions: The CCO must ensure that it has a policy or process for notifying existing members annually of the availability of a member handbook and provider directory and how to access those materials. The CCO must ensure that it tracks the timeliness of these communications.		

Standard XIV—Member Information (42 CFR §438.10)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
15. The member handbook provided to members following enrollment includes: a. The amount, duration, and scope of benefits available under the contract in sufficient detail to ensure that members understand the benefits to which they are entitled, and to effectively use the managed care program. b. Procedures for obtaining benefits, including authorization requirements and/or referrals for specialty care and for other benefits not furnished by the member's primary care provider. c. The extent to which and how members may obtain benefits, including family planning services and supplies from out-of-network providers. d. An explanation that the CCO cannot require the member to obtain a referral before choosing a family planning provider in- or out-of-network. e. The process of selecting and changing the member's primary care provider. f. Any restrictions on the member's freedom of choice among network providers. g. In the case of a counseling or referral service that the CCO does not cover due to moral or religious objections, the CCO informs the member that the service is not covered by the CCO and how the member can obtain information from the State about how to access such services. *42 CFR §438.10(g)(2)* *Contract: Exhibit B Part 3 (5)(a)(1)* *OAR 410-141-3585 (12)*	**Suggested Documents:** • Policies and procedures on member materials and dissemination of information to members • Member handbook **Documents Submitted for Desk Review:** • CHA.Member.Handbook.202204 (pg. 13, 14-24, 26-27, 36-37, 50, 55)	☐ Met ☒ Partially Met ☐ Not Met

Standard XIV—Member Information (42 CFR §438.10)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
HSAG Findings: The CCO's member handbook provided information on all subjects within the element in sufficient detail to allow a member to understand included and excluded benefits, referral and prior authorization requirements, service limitations, and the services available by and limitations to out-of-network care. The member handbook included statements that CHA did not have any moral or religious objections and would provide all OHP-covered services. However, the handbook stated that members were restricted to changing their PCP to once every six months, which contradicted 42 CFR §438.52 and CCO contract language. This limitation was also not consistent with OHA's 2023 model member handbook, which removed all language related to limiting members' ability to change PCPs. During the site visit, CCO staff members stated that they would not place restrictions on the number of PCP changes allowed and that the member handbook would be corrected to reflect their operational practices. This requirement was *Partially Met*.		
Required Actions: The CCO must ensure that its policies, procedures, and member materials are compliant with 42 CFR §438.52 regarding limitations on a member's ability to change PCPs. Specifically, the CFR and CCO Contract, Exhibit B, Part 3 (2)(g) directed CCOs to "Allow each Member to choose the Member's own Health Care Professional from available Participating Providers and facilities to the extent possible and appropriate. For a Member in a Service Area serviced by only one CCO, any limitation the Contractor imposes on the Member's freedom to change between Primary Care Providers or to obtain services from Non-Participating Providers if the service or type of Provider is not available with the Contractor's Provider Network may be no more restrictive than the limitation on Disenrollment under Sec. 9, below of this Ex. B, Part 3."		
16. The member handbook provided to members following enrollment includes member rights and responsibilities. As specified in 42 CFR §438.100, a member has the right to: • Receive information in accordance with information requirements (42 CFR §438.10). • Be treated with respect and with due consideration for his or her dignity and privacy. • Receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand. • Participate in decisions regarding his or her health care, including the right to refuse treatment. • Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.	**Suggested Documents:** • Policies and procedures on member materials and dissemination of information to members • Member Handbook **Documents Submitted for Desk Review:** • CHA.Member.Handbook.202204 (pg. 2, 9, 10, 30, 57) • Dissemination of Information PP07011 (pg. 1 section 3.2)	☒ Met ☐ Partially Met ☐ Not Met

Standard XIV—Member Information (42 CFR §438.10)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
• Request and receive a copy of his or her medical records, and request that they be amended or corrected. • Be furnished health care services in accordance with requirements for access, coverage, and coordination of medically necessary services (42 CFR §438.206 through 42 CFR §438.210). • Freely exercise his or her rights, and the exercising of those rights will not adversely affect the way the CCO, its network providers, or the State Medicaid agency treats the member. *42 CFR §438.10(g)(2)(ix)* *Contract: Exhibit B Part 3 (5)(a)(1)* *OAR 410-141-3585 (12)*		
HSAG Findings: This requirement was *Met*.		
Required Actions: None.		
17. The member handbook provided to members following enrollment includes the following information regarding the grievance, appeal, and contested case hearing procedures and time frames: a. The right to file grievances and appeals. b. The requirements and time frames for filing a grievance or appeal. c. The right to a request a Contested case hearing after the CCO has made a determination on a member's appeal which is adverse to the member. d. The availability of assistance in the filing process for grievances and appeals. e. The fact that, when requested by the member:	**Suggested Documents:** • Policies and procedures on member materials and dissemination of information to members • Member handbook **Documents Submitted for Desk Review:** • CHA.Member.Handbook.202204 (pg. 53, 54)	☐ Met ☒ Partially Met ☐ Not Met

Standard XIV—Member Information (42 CFR §438.10)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
i. Benefits that the CCO seeks to reduce or terminate will continue if the member files an appeal or a request for Contested case hearing is filed within the time frames specified for filing. ii. If benefits continue during the appeal or Contested case hearing process, the member may be required to pay the cost of services while the appeal or Contested case hearing is pending if the final decision is adverse to the member. *42 CFR §438.10(g)(2)(xi)* *Contract: Exhibit B Part 3 (5)(a)(1)* *OAR 410-141-3585 (12)*		
HSAG Findings: The CCO's member handbook included sections that provided information on the grievance, appeal, and administrative hearings rights and processes. However, while the member handbook included the right to file grievances and appeals and provided the correct time frame for filing an appeal (i.e., within 60 days from the date of a notice of adverse benefit determination [NOABD]), it did not provide any time frame for filing a grievance (i.e., at any time). The member handbook included the right to request a contested case hearing as well as the requirements and time frames for doing so and provided information on the availability of assistance in the filing process for grievances and appeals. The member handbook stated that benefits the CCO seeks to reduce or terminate could continue if the member files an appeal or a request for a contested case hearing is filed within the time frames specified for filing. However, while the member handbook correctly stated that members might be required to pay the cost for services while a contested case hearing was pending if the final decision was adverse to the member, it did not appear to state this correctly in the context of an appeal. The member handbook stated that in the case of continued benefits during an appeal, if the member continued the service and the reviewer agreed with the original decision (i.e., to deny the service), the member would not have to pay the cost of services received during the review period. This requirement was *Partially Met*.		
Required Actions: The CCO must ensure that its member handbook includes the time frame for filing a grievance. The CCO must also ensure that the member handbook clearly states that if benefits continue during the appeal process, the member may be required to pay the cost of services while the appeal is pending if the final decision is adverse to the member.		
18. The member handbook provided to members following enrollment includes the extent to which and how after-hours and emergency coverage are provided, including:	**Suggested Documents:** • Policies and procedures on member materials and dissemination of information to members	☒ Met ☐ Partially Met ☐ Not Met

Standard XIV—Member Information (42 CFR §438.10)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
a. What constitutes an emergency medical condition and emergency services. b. The fact that prior-authorization is not required for emergency services. c. The fact that the member has the right to use any hospital or other setting for emergency care. *42 CFR §438.10(g)(2)(v)* *Contract: Exhibit B Part 3 (5)(a)(1)* *OAR 410-141-3585 (12)*	• Member handbook **Documents Submitted for Desk Review:** • CHA.Member.Handbook.202204 (pg. 9, 18, 22, 25)	
HSAG Findings: The CCO's member handbook provided information to members regarding how after-hours and emergency coverage was provided. The handbook provided examples of emergency medical conditions. The section of the handbook relating to member rights stated that prior authorization was never required for emergency services. This requirement was *Met*.		
Required Actions: None.		
Recommendations: While the member handbook was compliant with the requirement, some of the language in the section related to emergency and after-hours care made potentially confusing statements that "in an emergency, you can call your provider's office and talk to a nurse or provider at any time," and "if the office is not open, you can still talk to the on-call nurse or provider." These instructions might discourage a member from seeking emergency care as soon as necessary or may be interpreted to mean that prior authorization is required for some emergency care. Additionally, there was no statement that members had the right to use any hospital or other setting for emergency care. Instead, the member handbook stated, "If you really think you have a health emergency, we cover emergency care near where you are." This language might be interpreted by members to mean that they must seek emergency care within the network rather than their physical location. Therefore, HSAG recommends that the CCO review and update the member handbook to ensure that it gives succinct, consistent, and unambiguous assertions that members may seek emergency care without prior authorization and have it covered anywhere and at any time.		
19. The member handbook provided to members following enrollment includes: a. Cost-sharing, if any is imposed under the State plan. b. How and where to access any benefits that are available under the State plan but not covered under the Medicaid managed care contract. c. How transportation is provided.	**Suggested Documents:** • Policies and procedures on member materials and dissemination of information to members • Member handbook **Documents Submitted for Desk Review:**	☒ Met ☐ Partially Met ☐ Not Met

Standard XIV—Member Information (42 CFR §438.10)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
d. The toll-free telephone number for member services, medical management, and any other unit providing services directly to members. e. Information on how to report suspected fraud or abuse. f. How to access auxiliary aids and services, including information in alternative formats or languages. *42 CFR §438.10(g)(2)(ii, viii, xiii, xiv, xv)* *Contract: Exhibit B Part 3 (5)(a)(1)* *OAR 410-141-3585 (12)*	• CHA.Member.Handbook.202204 (pg. 2, 7, 42, 45, 47, 53, 55, 56, 58)	
HSAG Findings: This requirement was *Met*.		
Required Actions: None.		
20. The member handbook provided to members following enrollment includes how to exercise an advance directive as required in §438.3 (j). *42 CFR §438.10(g)(2)(xii)* *Contract: Exhibit B Part 3 (5)(a)(1)* *OAR 410-141-3585 (12)*	**Suggested Documents:** • Policies and procedures on member materials and dissemination of information to members • Member handbook **Documents Submitted for Desk Review:** • CHA.Member.Handbook,.202204 (pg. 43-44)	☒ Met ☐ Partially Met ☐ Not Met
HSAG Findings: This requirement was *Met*.		
Required Actions: None.		
21. The CCO must give members written notice of any significant change (as defined by the State) in the information required at 42 CFR §438.10(g) at least 30 days before the intended effective date of the change. *42 CFR §438.10(g)(4)* *Contract: Exhibit B Part 3 (4)(i)* *AR 410-141-3585 (3)(f)*	**Suggested Documents:** • Example notification (if applicable within the last year) • Template letter (if available) **Documents Submitted for Desk Review:**	☐ Met ☒ Partially Met ☐ Not Met

Standard XIV—Member Information (42 CFR §438.10)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	• Not applicable for 2022. There were no significant changes.	
HSAG Findings: The CCO did not have a policy or procedure that addressed giving members written notice of any significant change related to OHP benefits and coverage at least 30 days before the intended effective date of the change. During the site visit, CCO staff members stated that their approach once aware of a significant change would be to update the member handbook and/or send a written communication depending on the type of change. CCO staff stated that dissemination of information would be tracked for timeliness in the Essette system. This requirement was *Partially Met*.		
Required Actions: The CCO must ensure that it has a policy or procedure which provides a process for giving members written notice of any significant change (as defined by the State) in the information required at 42 CFR §438.10(g) at least 30 days before the intended effective date of the change.		
22. The CCO provides member information by either: a. Mailing a printed copy of the information to the member's mailing address. b. Provides the information by email after obtaining the member's agreement to receive the information by email. c. Posts the information on the web site of the CCO and advises the member in paper or electronic form that the information is available on the Internet and includes the applicable Internet address, provided that members with disabilities who cannot access this information online are provided auxiliary aids and services upon request at no cost. d. Provides the information by any other method that can reasonably be expected to result in the member receiving that information. *42 CFR §438.10(g)(3)* *Contract: Exhibit B Part 3 (4)(d)*	**Suggested Documents:** • Policies and procedures on member materials and dissemination of information to members • Member welcome or introductory materials • Website links/screenshots • Evidence of mailings • Evidence of emails **Documents Submitted for Desk Review:** • Member Experience New Member Pack Process • Screenshot Language Access Statement JPG. From: https://www.cascadehealthalliance.com/for-members/member-resources-and-forms/ • OHP-CHA-19-090_Welcome.Letter • CHA.Member.Handbook.202204 (pg. 8, 14)	☐ Met ☒ Partially Met ☐ Not Met

Standard XIV—Member Information (42 CFR §438.10)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
HSAG Findings: The CCO's *Member Experience New Member Pack* policy and procedure detailed how information is to be provided to new and returning members via printed copies of the member handbook and welcome letter. The CCO's member handbook stated that the CCO would provide the information to members by email with the member's agreement, but this was not reflected in any policy or procedure; the member handbook is not a substitute for policy. During the site visit, CCO staff stated that the Member Services department would obtain consent or preference for communication with a member via email when engaging with members by phone. This requirement was *Partially Met.*		
Required Actions: The CCO must ensure it has policies and procedures which address the provision of information to members by email with their consent.		

Results for Standard XIV—Member Information							
Total	Met	=	11	X	1.0	=	11.0
	Partially Met	=	7	X	0.5	=	3.5
	Not Met	=	4	X	0.0	=	0.0
Total Applicable		=	22	**Total Score**		=	14.5

Total Score ÷ Total Applicable	=	**65.9%**

Standard XVI—Emergency and Poststabilization Services

Standard XVI—Emergency and Poststabilization Services (42 CFR §438.114)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
1. The CCO defines "emergency medical condition" as a condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following: a. Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; b. Serious impairment to bodily functions; or c. Serious dysfunction of any bodily organ or part. *42 CFR §438.114(a)* *Contract: Exhibit A* *OAR 410-120-0000*	**Suggested Documents:** • Emergency and poststabilization services coverage policies and procedures • Member handbook • Provider handbook or other provider messaging **Documents Submitted for Desk Review:** • Cascade Health Alliance Provider Manual Pg 19 (uploaded to Standard III) • Cascade Health Alliance Member Handbook page. 25, page 63 (uploaded to Standard III) • Emergency.Post.Stabilization.PP06020, page. 3; 6.1 • Emergency.Dental.Services.PP06019 page 4, 6.1 & 6.2 • Emergent.Urgent.Claims.Processing. PP03005; 6.2	☐ Met ☒ Partially Met ☐ Not Met
HSAG Findings: The *Emergency Dental Services* policy defined emergency medical conditions as specified in this element. The member handbook included appropriate, user-friendly language to describe emergency medical conditions consistent with the definition required by this element. However, the *Emergency Post Stabilization* policy and provider manual incorrectly defined "emergency services" using the definition that is specified in this element for "emergency medical conditions," and the *Emergent Urgent Claims Processing* policy did not include a definition for "emergency medical conditions." Note: The CCO's *Emergency Dental Services*, *Emergency Post Stabilization*, and *Emergent Urgent Claims Processing* policies had not been reviewed since 07/31/2019. This requirement was *Partially Met*.		

Standard XVI—Emergency and Poststabilization Services (42 CFR §438.114)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
Required Actions: The CCO must revise its *Emergency Post Stabilization* and *Emergent Urgent Claims Processing* policies and its provider manual to include the required definition of an "emergency medical condition."		
Recommendations: HSAG recommends the CCO ensure the *Emergency Dental Services*, *Emergency Post Stabilization*, and *Emergent Urgent Claims Processing* policies are reviewed and dated in accordance with its internal process, outlined in the CCO Overview Form, which indicated policies are reviewed annually. This recommendation applies to all elements that document a review of the previously mentioned policies.		
2. The CCO defines "emergency services" as covered inpatient or outpatient services furnished by a provider that is qualified to furnish these services under this title and are needed to evaluate or stabilize an emergency medical condition. *42 CFR §438.114(a)* *Contract: Exhibit A* *OAR 410-120-0000*	**Suggested Documents:** • Emergency and poststabilization services coverage policies and procedures • Member handbook • Provider handbook or other provider messaging **Documents Submitted for Desk Review:** • Cascade Health Alliance Member Handbook page. 63 • Emergency.Post.Stabilization.PP06020, page. 3; 6.1 • Emergency.Dental.Services.PP06019 page 4, 6.1 & 6.2 • Access.to.Care.PP06002 – p. 3; 6.1 & 6.4 (uploaded to Standard III)	☐ Met ☒ Partially Met ☐ Not Met
HSAG Findings: The *Emergency Post Stabilization* policy defined "emergency services" as specified in this element. The member handbook used appropriate, user-friendly language to describe "emergency services" that was consistent with the definition required by this element. However, the *Emergency Dental Services* and *Emergent Urgent Claims Processing* policies did not specifically define "emergency services," although the term was used in the policy, and the provider manual defined "emergency services" using the definition that is required for "emergency medical condition." This requirement was *Partially Met.*		

Standard XVI—Emergency and Poststabilization Services (42 CFR §438.114)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
Required Actions: The CCO must revise its *Emergency Dental Services* and *Emergent Urgent Claims Processing* policies and its provider manual, to include the required definition of "emergency services."		
3. The CCO defines "post stabilization care services" as covered services related to an emergency medical condition that are provided after a member is stabilized in order to maintain the stabilized condition or provided to improve or resolve the member's condition. *42 CFR §438.114(a)* *Contract: Exhibit A*	**Suggested Documents:** • Emergency and poststabilization services coverage policies and procedures • Member handbook or other member messaging • Provider handbook or other provider messaging **Documents Submitted for Desk Review:** • Cascade Health Alliance Member Handbook page 70 • Emergency.Post.Stabilization.PP06020, page. 3; 6.2 • Access.to.Care.PP06002 page 4; 6.2	☐ Met ☒ Partially Met ☐ Not Met
HSAG Findings: The *Emergency Post Stabilization* policy defined "post-stabilization care services" as specified in this element. The member handbook used appropriate, user-friendly language to describe "post-stabilization services" that was consistent with the definition required by this element. However, the provider manual did not define "post-stabilization care services." This requirement was *Partially Met.*		
Required Actions: The CCO must revise its provider manual to include the required definition of "poststabilization care services."		
4. The CCO may not require prior authorization for emergency services. *42 CFR §438.10(g)(2)(v)(B)* *Contract: Exhibit B Part 2(4)(a)(1)* *OAR 410-141-3835(2)* *OAR 410-141-3840(4)*	**Suggested Documents:** • Emergency and poststabilization services coverage policies and procedures **Documents Submitted for Desk Review:** • Cascade Health Alliance Member Handbook- page. 9, 21, 25, 36	☒ Met ☐ Partially Met ☐ Not Met

Standard XVI—Emergency and Poststabilization Services (42 CFR §438.114)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	• Cascade Health Alliance Provider Manual, page. 19, 40, 43 • Emergency.Post.Stabilization.PP06020, page. 1; 3.1 • Emergency.Dental.Services.PP06019 page 2, 4.2 & 4.3 • BH Auth Grid (Uploaded to Standard III) • Auth-Grid-Final (Uploaded to Standard III) • Turnaround.Time.PP06014 – p. 2; 4.9 (Uploaded to Standard IV) • Emergent.Urgent.Claims.Processing. PP03005; 4.2	
HSAG Findings: This requirement was *Met.*		
Required Actions: None.		
5. The CCO covers and pays for emergency services regardless of whether the provider that furnishes the services has a contract with the CCO. *42 CFR §438.114(c)(1)(i)* *Contract: Exhibit B Part 2(4)(a)(3)*	**Documents Submitted for Desk Review:** • Cascade Health Alliance Member Handbook- page. 25, 26, 31 • Cascade Health Alliance Provider Handbook, page. 24 • Emergency.Post.Stabilization.PP06020, page. 1; 3.1 • Emergent.Urgent.Claims.Processing. PP03005; 1.1, 3.1	☐ Met ☒ Partially Met ☐ Not Met
HSAG Findings: The *Emergent Urgent Claims Processing* policy stated that the CCO would pay for all emergent services without prior authorization, regardless of whether the member received care from in- or out-of-network providers. The *Emergency Post Stabilization* policy and procedure specified that the CCO would remove all financial and administrative barriers to emergency services, though it did not specifically state that it pays for out-of-network emergency services. However, this was stated within the *Emergent Urgent Claims Processing*		

Standard XVI—Emergency and Poststabilization Services (42 CFR §438.114)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
policy. The member handbook communicated that permission is not needed to obtain emergency services and that CHA pays for them in any location in the United States. However, page 16 of the member handbook stated that prior authorization is required for out-of-area emergency dental services. During the site visit, the CCO reported that the member handbook was updated for CY 2023 and no longer includes the prior authorization requirement for out-of-area emergency dental services, which was confirmed by the reviewer. The member handbook also instructed members to call the CCO after receiving care outside of the CHA service area or if the member receives a bill, and the CCO will assist the member in resolving the billing issue. The CCO also reported having a process for coordinating with OHA for Division of Medical Assistance Programs registrations. This requirement was *Partially Met.*		
Required Actions: There are no additional required actions for this finding because the CCO has revised its CY 2023 member handbook.		
6. The CCO may not deny payment for treatment obtained under either of the following circumstances: a. A representative of the CCO's organization (including the member's primary care provider) instructed the member to seek emergency services. b. A member had an emergency medical condition, including cases in which the absence of immediate medical attention would *not* have resulted in the following outcomes specified in the definition of an emergency medical condition. i. Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; ii. Serious impairment to bodily functions; or iii. Serious dysfunction of any bodily organ or part. *Note: The CCO bases its coverage decisions for emergency services on the severity of the symptoms at the time of presentation and covers emergency services when the presenting symptoms are of sufficient severity to constitute an emergency medical condition in the judgment of a prudent layperson. 42 CFR §438.114--Preamble*	**Suggested Documents:** • Emergency and poststabilization services coverage policies and procedures • Claims payment workflows and/or protocols – specific to payment and denials of emergency services **Documents Submitted for Desk Review:** • Cascade Health Alliance Member Handbook- page. 25 • Cascade Health Alliance Provider Manual, page. 19 • Access.to.Care.PP06002 page 2; 4.9 • Emergent.Urgent.Claims.Processing. PP03005; 3.1, 4.3.1, 6.2	☒ Met ☐ Partially Met ☐ Not Met

Standard XVI—Emergency and Poststabilization Services (42 CFR §438.114)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
42 CFR §438.114(c)(1)(ii) *Contract: Exhibit B Part 2(4)(a)(5) and (11)* *OAR 410-141-3840(4) and (5)*		
HSAG Findings: This requirement was *Met.*		
Required Actions: None.		
7. The CCO does not: a. Limit what constitutes an emergency medical condition based on a list of diagnoses or symptoms. b. Refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the member's primary care provider, the CCO, or State agency of the member's screening and treatment within 10 calendar days of presentation for emergency services. *42 CFR §438.114(d)(1)* *Contract: Exhibit B Part 2(4)(a)(1) and (10)* *OAR 410-141-3840(4)(b) and (c)*	**Suggested Documents:** • Emergency and poststabilization services coverage policies and procedures • Claims payment workflows and/or protocols – specific to payment and denials of emergency services **Documents Submitted for Desk Review:** • Emergency.Post.Stabilization.PP06020, page. 1; 3.1, 3.3 • Emergent.Urgent.Claims.Processing. PP03005; 4.4, 4.5	☒ Met ☐ Partially Met ☐ Not Met
HSAG Findings: This requirement was *Met.*		
Required Actions: None.		
8. The CCO does not hold a member who has an emergency medical condition liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient. *42 CFR §438.114(d)(2)* *Contract: Exhibit B Part 2(4)(a)(9)* *OAR 410-141-3840(4)*	**Suggested Documents:** • Emergency and poststabilization services coverage policies and procedures • Claims payment workflows and/or protocols – specific to coverage of poststabilization services • Provider messaging	☒ Met ☐ Partially Met ☐ Not Met

Standard XVI—Emergency and Poststabilization Services (42 CFR §438.114)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	Documents Submitted for Desk Review: • Cascade Health Alliance Member Handbook-page. 43 • Cascade Health Alliance Provider Handbook, page. 55 billing members • Emergency.Post.Stabilization.PP06020 - p. 1; 3.1 • Access.to.Care.PP06002 – p. 2; 4.8 • Emergent.Urgent.Claims.Processing. PP03005; 4.5	
HSAG Findings: This requirement was *Met.*		
Required Actions: None.		
9. The CCO allows the attending emergency physician, or the provider actually treating the member, to be responsible for determining when the member is sufficiently stabilized for transfer or discharge, and that determination is binding on the CCO who is responsible for coverage and payment. *42 CFR §438.114(d)(3)* *Contract: Exhibit B Part 2(4)(a)(9)*	**Suggested Documents:** • Emergency and poststabilization services coverage policies and procedures • Claims payment workflows and/or protocols – specific to poststabilization services • Provider messaging **Documents Submitted for Desk Review:** • Emergency.Post.Stabilization.PP06020, page. 1; 3.4 • Emergent.Urgent.Claims.Processing. PP03005; 4.6	☒ Met ☐ Partially Met ☐ Not Met
HSAG Findings: The *Emergency Post Stabilization* and *Emergent Urgent Claims Processing* policies addressed the specified requirement. The *Emergent Urgent Claims Processing* policy specified that the attending emergency physician or the provider treating the member is responsible for determining when the member is sufficiently stabilized for transfer or discharge and that CHA will cover that service.		

Standard XVI—Emergency and Poststabilization Services (42 CFR §438.114)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
During the site visit, the CCO described its process for collaborating with the treating provider and case manager at the hospital to coordinate the member's ongoing care. This process was explained within the Utilization Review Plan submitted for the Coverage and Authorization of Services standard. Note: The Utilization Review Plan has not been reviewed since 9/21/2018. This requirement was *Met.*		
Required Actions: None.		
Recommendations: HSAG recommends that the CCO ensure the Utilization Review Plan is reviewed and dated according to its internal process, outlined in the CCO Overview Form, which indicates that policies are reviewed annually. This recommendation applies to all elements that document a review of this document.		
10. The CCO is financially responsible for poststabilization services that are: a. ***Pre-approved*** by a plan provider or CCO representative, regardless of whether they are provided within or outside the CCO's network of providers. b. Obtained within or outside the network that are ***not pre-approved*** by a plan provider or other organization representative but are administered to maintain the member's stabilized condition within one hour of a request to the organization for pre-approval of further poststabilization care services. c. Obtained within or outside the network that are ***not pre-approved*** by a plan provider or other organization representative, but are administered to maintain, improve, or resolve the member's stabilized condition if: i. The organization does not respond to a request for pre-approval within one hour; ii. The organization cannot be contacted; or iii. Services are provided and when the organization representative and the treating physician cannot	**Suggested Documents:** • Emergency and poststabilization services coverage policies and procedures • Claims payment workflows and/or protocols – specific to poststabilization services • Provider messaging **Documents Submitted for Desk Review:** • Emergency.Post.Stabilization.PP06020, page. 1; 3.1, page. 2; 3.5 • Access.to.Care.PP06002 page 3; 4.12 • Emergent.Urgent.Claims.Processing. PP03005; 4.3.1, 4.3.2, 4.3.2.1	☒ Met ☐ Partially Met ☐ Not Met

Standard XVI—Emergency and Poststabilization Services (42 CFR §438.114)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
reach an agreement concerning the member's care and a plan physician is not available for consultation. In this situation, the organization must give the treating physician the opportunity to consult with a plan physician, and the treating provider may continue with care of the patient until a plan provider is reached or one of the criteria in §422.113(c)(3) is met. *42 CFR §438.114(e); 422.113(c)(2)(i-iii)* *Contract: Exhibit A and Exhibit B Part 2(4)(a)(6) and (8)* *OAR 410-141-3840(5)*		
HSAG Findings: This requirement was *Met.*		
Required Actions: None.		
11. The CCO's financial responsibility for post stabilization care services it has not pre-approved ends when: a. A plan physician with privileges at the treating hospital assumes responsibility for the member's care; b. A plan physician assumes responsibility for the member's care through transfer; c. A plan representative and the treating physician reach an agreement concerning the member's care; or d. The member is discharged. *42 CFR §438.114(e); 422.113(c)(3)(i-iv)* *Contract: Exhibit B Part 2(4)(a)(7)* *OAR 410-141-3840(6)*	**Suggested Documents:** • Emergency and poststabilization services coverage policies and procedures • Claims payment workflows and/or protocols - specific to poststabilization services **Documents Submitted for Desk Review:** • Emergency.Post.Stabilization.PP06020, page. 2; 3.7 • Access.to.Care.PP06002 page 3; 4.13 • Emergent.Urgent.Claims.Processing. PP03005; 4.3.2.3	☒ Met ☐ Partially Met ☐ Not Met
HSAG Findings: This requirement was *Met.*		
Required Actions: None.		

Standard XVI—Emergency and Poststabilization Services (42 CFR §438.114)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
12. In the event the member receives emergency or post stabilization services from a provider outside the CCO's network, the CCO must limit charges to the member to an amount no greater than what the CCO would charge if he or she had obtained the services through an in-network provider. *42 CFR §438.114(e); 422.113(c)(2)(iv)* *Contract: Exhibit B Part 2(4)(a)(6)* *OAR 410-141-3840(8)*	**Suggested Documents:** • Emergency and poststabilization services coverage policies and procedures • Example of communication to out-of-network emergency provider • Member messaging related to financial liability **Documents Submitted for Desk Review:** • Emergency.Post.Stabilization.PP06020, page. 1; 3.1 • Out.of.Network.PP06012 page 1; 1.1.2 • Emergent.Urgent.Claims.Processing. PP03005; 4.3.3	☒ Met ☐ Partially Met ☐ Not Met
HSAG Findings: The *Emergent Urgent Claims Processing* and *Out of Network* policies addressed the specified requirements of this element. The *Emergency Post Stabilization* policy did not include the specific requirements of this element. However, it was addressed in the previously noted relevant policies. During the site visit, the CCO reported that its policy included language related to cost-sharing to comply with the stated requirements. However, members do not have any cost-sharing responsibilities. In addition, the CCO described its process for informing providers that they may not balance bill members, and the member handbook informed members that they should call the CCO for assistance if they get a bill from a provider. Note: The *Out of Network* policy has not been reviewed/approved since 10/15/2018. This requirement was *Met.*		
Required Actions: None.		
Recommendations: HSAG recommends that the CCO update its *Emergent Urgent Claims Processing* policy to clarify that members do not have any cost-sharing responsibilities. In addition, HSAG also recommends that the CCO ensure the *Out of Network* policy is reviewed and dated in accordance with its internal process, outlined in the CCO Overview Form, which indicated that policies are reviewed annually.		

Standard XVI—Emergency and Poststabilization Services							
Total	Met	=	8	X	1.0	=	8.0
	Partially Met	=	4	X	0.5	=	2.0
	Not Met	=	0	X	0.0	=	0.0
Total Applicable		=	12	**Total Score**		=	10.0

Total Score ÷ Total Applicable	=	**83.3%**

Appendix B. CY 2022 Improvement Plan Findings

Following this page is the completed CY 2022 IP that includes HSAG's assessment of resolution for CHA's findings from previous CMRs.

2021 Findings

Standard I—Availability of Services	
Element #7	Regarding timely access to care and services, the CCO: a. Ensures that network providers offer hours of operation that are no less than the hours of operation offered to commercially insured members or comparable to Medicaid FFS, if the provider serves only Medicaid members. b. Has a mechanism to ensure compliance with timely access standards and hours of operation. c. Monitors network providers regularly to determine compliance. d. Takes corrective action if a network provider fails to comply with these access requirements. *42 CFR §438.206(c)(1)* *Contract: Exhibit G (1)(d)* *Contract: Exhibit B Part 4 (2)(a),(d)* *OAR 410-141-3515 (13)*
Finding #6: The *Network Adequacy Timely Access* policy asserted the CCO monitors providers regularly and reports concerns to the Provider Network Management Committee, who would take corrective action "when necessary." The Provider Secret Shopper Calls Process desk procedure indicated quarterly calls would be made to primary care provider (PCP) COMPLIANCE MONITORING REVIEW RESULTS—Draft Copy for Review—Cascade Health Alliance, LLC 2021 Compliance Monitoring Review Report Page 3-4 State of Oregon CHA_OR2021_CMR_CCO_ComplianceReport_D1_1121 clinics. The procedure did not include monitoring of specialists, behavioral health providers, or oral health providers, and the CCO was unable to provide evidence of monitoring. Discrepancies were noted between the *Network Adequacy Timely Access* and *Access to Care* policies for appointment time frame standards, and CCO staff members were unable to articulate which appointment time frame standards were used during secret shopper calls to determine compliance with access standards. The CCO was also unable to provide evidence of corrective action for providers who failed to meet network access standards and delayed corrective action until "excessive grievances" were identified. This requirement was *Not Met*.	
Required Action: CHA must ensure there are established mechanisms in place to monitor network providers and take corrective action when providers fail to comply with network standards.	

Standard I—Availability of Services			
CCO Improvement Plan			
CCO Action Plan/Interventions		**Individual(s) Responsible**	**Completion Date**
Updated Network.Adequacy.Timely.Access.PP07002		Biagio Sguera	2/2022
Documentation Submitted as Evidence	Network.Adequacy.Timely.Access.PP07002: Access, Monitoring and Corrective Action Section		
HSAG Assessment of Resolution	CHA submitted its revised *Network Adequacy Timely Access* policy, which asserted the CCO would ensure compliance with timely access standards and hours of operation by monitoring network providers regularly and take access, barriers or concerns to the PNMC to assess non-compliance. The policy outlined its methodology for monitoring the provider network, which included secret shopper surveys (at least quarterly) for primary care, oral care, behavioral health, and specialty providers to assess compliance with network access standards outlined within the policy and member surveys to assess members' perception of access wait times for primary, oral, behavioral health, and specialty care. In addition, the policy stated the CCO uses grievance and appeal data, Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey results, and information from the delivery system network (DSN) and provider capacity reporting required by OHA. The policy also asserted CHA would review data from appeals and grievances, consumer assessment surveys, secret shopper surveys during the monthly PNMC meetings and providers found to be out of compliance with guidelines and time frames would be put on a corrective action plan. Per committee recommendations, providers shall be issued a written warning of non-compliance with a short cure period, which is then followed up with a corrective action plan. The policy indicated the PNMC would monitor the remedies and mitigation standards	☐ Resolved ☐ Resolved, with recommendations ☒ Not Resolved	

Standard I—Availability of Services		
	outlined in the corrective action plan for provider compliance, next steps, completion, and/or possible discharge of the provider. During the virtual "onsite" review, CHA discussed its efforts to monitor accessibility of the provider network and showed the dashboards used during the PNMC meetings. The reviewer asked clarifying questions regarding the types of providers included in the secret shopper surveys, because behavioral health providers were not included in results presented. CHA reported behavioral health providers were not included in provider monitoring activities because behavioral health providers were "not required to contract with the health plan." However, this did not align with the CCO's policies or contractual requirement. CHA was asked to explain how it monitors hours of operation and the CCO reported hours of operation were monitored through provider site visits and during secret shopper calls; however, the CCO was unable to demonstrate monitoring hours of operation through the dashboard presentation or monitoring reports. Lastly, CHA was asked to describe its process for taking corrective action when providers fail to meet network access standards and the CCO reported a corrective action plan is only implemented when a provider meets the specified algorithmic threshold, which does not align with the requirement to "Take corrective action if there is a failure to comply by a network provider" as stated in 42 CFR 438.206 (c)(1)(vi). The CCO further reported it conducts outreach and provides education to providers before implementing a corrective action plan. CHA must demonstrate adherence to internal policies and contractual requirements to monitor behavioral health providers. If services are delegated to a subcontractor, the CCO must ensure monitoring and corrective actions are being conducted by the delegated entity. CHA must provide results of secret shopper calls, evidence of monitoring hours of operation, and corrective actions taken when providers identified during monitoring activities fail to meet network access standards. This finding remains **unresolved.**	

Standard I—Availability of Services		
CCO Status Update	As of January 2023, CHA has restructured its Secret Shopper Survey to include behavioral health. See Appropriate Access to Care Provider Shopper Calls, this includes data from secret shopper surveys confirming hours of operation for each clinic, specialist, or behavioral health provider. CHA continues to develop this data and review with its Provider Network Management Committee on a quarterly basis. We have also included samples of corrective action for providers.	
Documentation Submitted as Evidence	APPROPRIATE ACCESS TO CARE PROVIDER SHOPPER CALLS (uploaded in the initial submission on 4/20), TransLink_KBBH AG CAPs.pptx, Email TransLink CAP 6.13.23, Email Wade KBBH CAP 6.13.23, 0.CHA AG - Corrective.Action.Plan.KBBH, 0.CHA AG - Corrective.Action.Plan.KBBH, CHA_Notice_to_Terminate_Credentialing	
HSAG Assessment of Resolution	The CCO submitted its Appropriate Access to Care Provider Shopper Calls document, including calls conducted with primary care providers, dentists, specialists, and behavioral health providers during first quarter 2023. Data captured in the report also included office hours, acceptance of new patients, walk-in clinic availability, and appointment wait time. There was a column to record instructions for members regarding after-hours care, but no data were present in those fields. The reviewer noted providers listed as inactive, calls resulting in no answer, and providers not accepting CHA members. Wait time to appointment varied and included responses, such as "six to eight weeks for new patients, several months, October (which would be eight months from date of call), not too long, and N/A [not applicable]." The report did not include the appointment time frame standards used to determine compliance or whether the caller was requesting an appointment for urgent care, routine care, pregnant/non-pregnant/child oral care, or behavioral health care for priority populations. Further, it was not clear from the documentation provided what corrective actions were taken in response to results of the calls. The corrective action documentation submitted with the IP did not demonstrate corrective action was taken when providers identified during monitoring activities failed to meet network access standards. Examples of this included the following: • TransLink_KBBH AG CAPs.pptx—This was a PowerPoint presentation with information regarding corrective action plans (CAPs) for TransLink and KBBH subcontractors.	☐ Resolved ☐ Resolved, with recommendations ☒ Not Resolved

Standard I—Availability of Services		
	• Email TransLink CAP 6.13.23/0.CHA AG - Corrective.Action.Plan.NEMT—This CAP was related to grievances that did not have acknowledgement and resolution letters. • Email Wade KBBH CAP 6.13.23/0.CHA AG - Corrective.Action.Plan.KBBH—This CAP was related to grievances that did not have acknowledgement and resolution letters. • CHA_Notice_to_Terminate_Credentialing—This notice of termination was related to credentialing activities. To resolve this finding, CHA must demonstrate that it is monitoring compliance with all appointment availability standards (e.g., urgent and routine physical health, including specialists, urgent and routine dental health; including an assessment of pregnant vs. non-pregnant appointment time frames; and urgent and routine behavioral health, including priority populations). It must further demonstrate that it is taking corrective actions when providers identified during monitoring activities fail to meet network access standards. In addition, the CCO must address calls that resulted in no answer, offices which communicated that the provider was not accepting CHA members, etc., to eliminate barriers to members accessing care. At a minimum, the CCO must ensure the provider directory accurately reflects providers that are not currently accepting new members. This finding remains **unresolved**.	

Standard I—Availability of Services	
Element #8	The CCO has written policies and procedures that ensure scheduling and rescheduling of member appointments are appropriate to the reasons for and urgency of the visit. For physical health, the member is seen, treated, or referred within the following timeframes: a. *Well care:* Within four (4) weeks from the date of a patient's request. b. *Urgent care:* Within seventy-two (72) hours or as indicated in the initial screening fin accordance with OAR 410-141-3840. c. *Emergency care:* Seen and treated immediately or referred immediately to an emergency department depending on the member's condition. *42 CFR §438.206(c)(1)(i)* *Contract Exhibit B Part 4 (2)(a)* *OAR 410-141-3515 (11)(a)* *OAR 410-141-3840*
Finding: The *Network Adequacy Timely Access* and *Access to Care* policies correctly stated physical health scheduling time frames; however, the *Access to Care* policy referenced the repealed OAR 410-141-3220. The provider manual incorrectly stated a 60-day time frame for well-care visits and the access time frames were not communicated in the member handbook. This requirement was *Not Met*.	
Required Action: CHA must revise the provider manual to align with the four-week state-established time frame for well-care visits. CHA must communicate (e.g., via the member handbook) physical health access standards to members.	

CCO Improvement Plan

CCO Action Plan/Interventions	Individual(s) Responsible	Completion Date
Updates to Provider Manual and Member Handbook completed	Biagio Sguera	3/2022

Documentation Submitted as Evidence	Provider Manual_Feb 2022 pg 20 (17), CHA-Member Handbook 26P pg 30 (29)

Standard I—Availability of Services		
HSAG Assessment of Resolution	CHA submitted its revised member handbook and provider manual for review. The member handbook aligned with the state-established network access standards. However, HSAG also recommends a more user-friendly format (i.e., table) to communicate appointment time frame standards. CCOs are encouraged to use the OHA model member handbook template, which includes a table format as well as the correct dental care appointment time frame standards. The provider manual incorrectly communicated the following physical care access standards: • *Emergency Care Seen immediately or referred to an emergency department depending on the member's condition.* • *Urgent Care Seen within 72 hours or as indicated in initial screening in accordance with OAR 410-141-0140.* • *Well Care Seen within four weeks or within the established community standard in accordance with OAR 410-141- 0220.* The language used in the provider manual included repealed OAR citations for urgent and well care appointment time frames and including "or within the established community standard" for well care visits. CHA must ensure the provider manual aligns with state-established access standards and includes current OAR citations. This finding remains **unresolved.**	☐ Resolved ☐ Resolved, with recommendations ☒ Not Resolved
CCO Status Update	Updates to Provider Manual completed	
Documentation Submitted as Evidence	Provider Manual_Feb 2023 pg 20	
HSAG Assessment of Resolution	The "Accessibility: section (p. 17) of the draft provider manual was updated to reflect the state-established access standards for physical health. This includes the	☐ Resolved ☒ Resolved, with recommendations ☐ Not Resolved

Standard I—Availability of Services		
	removal of the statement that well care visits would be within four weeks "or within the established community standard with OAR 410-141-0220." However, during the review of Standard I, element 9, the reviewer noted that the draft *Network Adequacy Timely Access* policy included, "within four weeks or the community standard from the date of the member's request," for well-care visits. This discovery in the policy was not part of the initial finding and will not affect the approval of the IP finding. However, HSAG recommends that the CCO remove this statement from its policy to fully align with the state-established access standards to ensure compliance during the CY 2024 Standard I—Availability of Services review. The policy is currently in draft form, so the CCO is encouraged to make and implement the suggested change with the other changes. This finding is **resolved with recommendations**.	

Standard I—Availability of Services	
Element #9	For dental health, the member is seen, treated, or referred within the following timeframes: a. *Emergency dental care:* Seen or treated within twenty-four (24) hours. b. *Urgent dental care:* Within one (1) week or as indicated in the initial screening. c. *Routine dental care:* Within eight (8) weeks, unless there is a documented special clinical reason that makes a period of longer than 8 weeks appropriate. *42 CFR §438.206(c)(1)(i)* *Contract Exhibit B Part 2 (8)(d)* *OAR 410-141-3515 (11)(b)*
Finding: The *Access to Care* policy correctly stated the dental health care scheduling time frames; however, the *Network Adequacy Timely Access* policy and provider manual cited a two-week time frame for urgent dental care, which was out of compliance with the standard of one week. The *Emergency Dental Services* policy aligned with the 24-hour requirement for emergency dental care; however, it did not address the time frame for urgent dental care. In addition, access time frames were not communicated in the member handbook. This requirement was *Not Met*.	
Required Action: CHA must revise the *Network Adequacy Timely Access* policy and provider manual to reflect the state-established appointment time frames for urgent dental care. CHA should include the time frame for urgent dental care in the *Emergency Dental Services* policy and must communicate (e.g., via the member handbook) dental health access standards to members.	

CCO Improvement Plan

CCO Action Plan/Interventions	Individual(s) Responsible	Completion Date
Updated Emergency.Dental.Services.PP06019 and Member Handbook	Biagio Sguera	3/2022

Documentation Submitted as Evidence	Emergency.Dental.Services.PP06019 section 4.4, CHA-Member Handbook 26P pg 30 (29)	
HSAG Assessment of Resolution	CHA submitted its *Emergency Dental Services* policy, which was updated to include emergency dental services within 24 hours and urgent dental services within one week. The member handbook included correct dental care appointment time frames	☐ Resolved ☐ Resolved, with recommendations ☒ Not Resolved

Standard I—Availability of Services		
	for emergency, urgent (pregnant and children/non-pregnant individuals), and routine (children/non-pregnant individuals). However, the member handbook did not include the routine oral care time frame of "within four weeks, unless there is a documented special clinical reason that makes a period of longer than four weeks appropriate" for pregnant individuals. The *Network Adequacy Timely Access* policy included routine dental care within eight weeks "or the community standard," which does not align with the state-established network access standard of within eight weeks, unless there is a documented special clinical reason that makes a period of longer than 8 weeks appropriate. The provider manual did not appear to be revised and continued to contain incorrect dental care time frames. OHA has provided the following clarification for dental care appointment time frame standards for pregnant individuals and children/non-pregnant individuals: <u>Pregnant Individuals</u> • Emergency dental care: Seen or treated within twenty-four (24) hours. • Urgent dental care: Within one week or as indicated in the initial screening. • Routine dental care: Within four weeks, unless there is a documented special clinical reason that makes a period of longer than four weeks appropriate. <u>Children and Non-Pregnant Individuals</u> • Emergency dental care: Seen or treated within twenty-four (24) hours. • Urgent dental care: Within two weeks or as indicated in the initial screening. • Routine dental care: Within eight weeks, unless there is a documented special clinical reason that makes a period of longer than eight weeks appropriate. CHA must ensure all policies (i.e., *Emergency Dental Services* and *Network Adequacy Timely Access*), provider manual, and member handbook reflect dental care appointment time frames for pregnant and children/non-pregnant individuals. This finding remains **unresolved.**	

Standard I—Availability of Services		
CCO Status Update	Updated Network Adequacy Policy and the Provider Manual	
Documentation Submitted as Evidence	Network.Adequacy.Timely.Access.PP07002, Provider Manual_Feb 2023, CHA Member Handbook 02 2023 page 46,	
HSAG Assessment of Resolution	The *Emergency Dental Services* policy, draft provider manual, and finalized member handbook included the state-established dental care appointment time frames for emergent, urgent, and routine dental appointment time frames for both pregnant and children/non-pregnant individuals. The CCO removed the provision for dental care to be provided within the time frame established "or the community standard" from its draft *Network Adequacy Timely Access* policy. However, the time frames included in the policy reflected routine dental care for children and non-pregnant individuals (e.g., "Within eight weeks, unless there is a documented special clinical reason that makes a period of longer than eight weeks appropriate") and urgent dental care for pregnant individuals (e.g., "Within one week or as indicated in the initial screening"). The policy did not include urgent and routine dental appointment time frames for both pregnant and children/non-pregnant individuals. CHA must revise its draft *Network Adequacy Timely Access* policy to reflect dental care appointment time frames for individuals who are pregnant, non-pregnant, or children. This finding remains **unresolved**.	☐ Resolved ☐ Resolved, with recommendations ☒ Not Resolved

Standard I—Availability of Services	
Element #10	For behavioral health, the member is seen, treated, or referred within the following timeframes: a. *Urgent behavioral health treatment:* Within 24 hours. b. *Routine behavioral health treatment:* Seen for an intake assessment within 7 days of the request, with a second appointment occurring as clinically appropriate. *42 CFR §438.206(c)(1)(i)* *Contract Exhibit B Part 4 (2)(a)* *OAR 410-141-3515 (11)(c)(A)*
Finding: The *Access to Care* and *Access to Specialty Behavioral Health Services for Priority Populations* policies correctly stated the behavioral health care scheduling time frames; however, the *Network Adequacy Timely Access* policy and provider manual cited a two-week time frame for routine/nonurgent behavioral health treatment, which was out of compliance with the standard of seven days. In addition, neither the *Network Adequacy Timely Access* policy nor provider manual addressed urgent behavioral health treatment, and appointment access time frames were not communicated in the member handbook. This requirement was *Not Met*.	
Required Action: CHA must revise the *Network Adequacy Timely Access* policy and provider manual to reflect the state-established appointment time frame for routine/non-urgent behavioral health treatment. In addition, CHA must communicate (e.g., via the member handbook) behavioral health access standards to members.	

CCO Improvement Plan

CCO Action Plan/Interventions	Individual(s) Responsible	Completion Date
Updated Network.Adequacy.Timely.Access.PP07002, Provider Manual, and Member Handbook	Biagio Sguera	

Documentation Submitted as Evidence	Network.Adequacy.Timely.Access.PP07002 section 3.1.7, 3.1.8, Provider Manual_Feb 2022 pg 20 (17), and CHA-Member Handbook 26P pg 30 (29)	
HSAG Assessment of Resolution	CHA's *Network Adequacy Timely Access* policy and member handbook were revised to include the correct access standards for urgent and routine behavioral health services. However, the provider manual reflected an incorrect non-urgent/routine behavioral health time frame of "two weeks from the date of request."	☐ Resolved ☐ Resolved, with recommendations ☒ Not Resolved

Standard I—Availability of Services		
	CHA must revise its provider manual to reflect the correct routine behavioral health treatment access standard of an "intake assessment within seven days of the request, with a second appointment occurring as clinically appropriate." This finding remains **unresolved.**	
CCO Status Update	Updated Provider Manual submitted.	
Documentation Submitted as Evidence	Provider Manual_Feb 2023 (pg 20)	
HSAG Assessment of Resolution	The draft provider manual included the correct routine behavioral health treatment access standard of an "intake assessment within seven days of the request, with a second appointment occurring as clinically appropriate." This finding is **resolved**.	☒ Resolved ☐ Resolved, with recommendations ☐ Not Resolved

Standard II—Assurances of Adequate Capacity and Services	
Element #1	The CCO has a methodology to establish and monitor provider network capacity based on the following factors: a. The anticipated Medicaid enrollment and anticipated enrollment of full benefit dual eligible (FBDE) individuals. b. An appropriate range of preventive and specialty services, that is adequate for the population enrolled or expected to be enrolled in the service area. c. The expected utilization of services also taking into consideration the dental, physical and behavioral health care needs of members. d. The number and types (in terms of training, experience, and specialization) of providers required to provide services under the CCO contract. e. The geographical location and distribution, as required under ORS 414.609, of participating providers and members considering distance, travel time, the means of transportation ordinarily used by members and whether the location provides physical access for members with disabilities. f. The number of providers who are *not* accepting new members. g. The number of members assigned to PCPCHs. *42 CFR §438.207(b)(1-2)* *Contract: Exhibit B, Part 4 (3)(a)(2)* *Contract: Exhibit G (1)(a)* *OAR 410-141-3515 (1),(13)*
Finding: The CCO's *Network Adequacy Timely Access* policy outlined the methodology for monitoring the provider network capacity; however, it did not include anticipated enrollment of FBDE members, and the CCO was unable to demonstrate the inclusion of anticipated enrollment, including FBDE members, or expected utilization in its reporting. In addition, the reporting demonstrated the CCO monitored specialists as a single group rather than individual specialty type, which did not accurately represent whether CHA's specialty network is sufficient in number, mix, and geographic distribution. This requirement was *Partially Met*.	
Required Action: CHA must ensure its methodology for monitoring provider network capacity and evidence of monitoring includes all required elements as specified in federal and State requirements. In addition, CHA must monitor the provider network to ensure an appropriate range of preventive and specialty services that is adequate for the population enrolled or expected to be enrolled in the service area.	

Standard II—Assurances of Adequate Capacity and Services			
CCO Improvement Plan			
CCO Action Plan/Interventions		**Individual(s) Responsible**	**Completion Date**
Updated Network.Adequacy.Timely.Access.PP07002		Biagio Sguera	2/2022
Documentation Submitted as Evidence	Network.Adequacy.Timely.Access.PP07002: Access, Monitoring and Corrective Action Section		
HSAG Assessment of Resolution	CHA submitted its *Network Adequacy Timely Access* policy; however, revisions did not include anticipated enrollment of FBDE members or identify specialists monitored. The reviewer also noted a statement within section 4.1 of the policy indicating "routine travel time or distance to Patient-Centered Primary Care Home (PCPCH) or Primary Care Provider (PCP) will not exceed the community standard for accessing healthcare for 90 percent of members within the service area (per standards OAR 410-141-3220 (4)(b));" however, the state-established standard is 100 percent and the policy referred to a repealed OAR citation. During the virtual onsite review, CHA showed a dashboard that demonstrated monitoring anticipated enrollment of FBDE members. CHA also reported it has not started monitoring subcategories of specialist at this time but plans to conduct this monitoring in the future, however the CCO was not able to provide an anticipated completion date. To comply with State and federal regulatory requirements and resolve this finding, CHA must demonstrate monitoring the number, types, and geographic location of the specialty provider network for compliance with the state-established standards. This finding remains **unresolved.**	☐ Resolved ☐ Resolved, with recommendations ☒ Not Resolved	

Standard II—Assurances of Adequate Capacity and Services		
CCO Status Update	As of January 2023 CHA has restructured its Secret Shopper Survey to include specialist. See Appropriate Access to Care Provider Shopper Calls. CHA continues to develop this data and review same with its Provider Network Committee on a quarterly basis.	
Documentation Submitted as Evidence	APPROPRIATE ACCESS TO CARE PROVIDER SHOPPER CALLS	
HSAG Assessment of Resolution	To resolve this IP finding, the CCO was required to demonstrate monitoring the specialty provider network's number, types, and geographic location for state-established standards compliance. The CCO's response that it had restructured its secret shopper surveys to include specialists was not relevant to this finding. HSAG provided an additional opportunity for the CCO to resubmit documentation that demonstrates monitoring the specialty provider network's number, types, and geographic location for compliance with the state-established standards. The CCO's written response to the request indicated that the information was not available, which was confirmed with the CCO during the site visit. This finding remains **unresolved.**	☐ Resolved ☐ Resolved, with recommendations ☒ Not Resolved

Standard II—Assurances of Adequate Capacity and Services	
Element #3	When assessing its network capacity, the CCO identifies and incorporates the needs of linguistically and culturally diverse populations in the following ways: a. Monitors the sufficiency of language services. b. Develops an action plan to ensure its workforce is prepared to provide the physical, behavioral, and dental health services to members in its service area in a manner that is culturally and linguistically appropriate and trauma informed. c. Ensures its network providers and subcontractors deliver culturally and linguistically appropriate services as described in CLAS Standards, demonstrating both awareness for and sensitivity to cultural differences and similarities and the effect on the member's care. *Contract: Exhibit G 1(d), (2)(c)(6)* *Contract: Exhibit K (10)(a)(2)* *OAR 410-141-3515 (12)(d)*
Finding: The *Alternate Formats and Language Access* policy aligned with the requirement to ensure the delivery of services in a culturally and linguistically appropriate and trauma-informed manner to all members. The CCO communicated the availability of free oral, signed, and written language assistance in the provider manual and member handbook. A provider training deck, training log for providers, and evidence of grievance tracking related to race, ethnicity, language, and disability were submitted. However, the CCO was unable to provide evidence of monitoring of language services or demonstrate through committee meeting minutes or related documentation that it incorporated the cultural and linguistic needs of its member population in its evaluation of the provider network. This requirement was *Partially Met*.	
Required Action: CHA must demonstrate it incorporates the linguistically and culturally diverse needs of its member population into its evaluation of provider network capacity, including the monitoring of language services.	

CCO Improvement Plan

CCO Action Plan/Interventions	Individual(s) Responsible	Completion Date
CHA's Provider Network Department is working with other departments in the organization to collect more robust information on linguistic and culturally diverse needs of members, once reporting is collected this will become a standing agenda item to be presented and discussed at internal PNMC meetings.	Biagio Sguera	09/2022

Standard II—Assurances of Adequate Capacity and Services		
Documentation Submitted as Evidence		
HSAG Assessment of Resolution	CHA's IP response indicated the CCO has not completed development of a process for incorporating the linguistically and culturally diverse needs of its member population into its evaluation of provider network capacity. This finding remains **unresolved.**	☐ Resolved ☐ Resolved, with recommendations ☒ Not Resolved
CCO Status Update	CHA is improving its collection of language and interpretive data, which now includes members by spoken language, interpreter claims by type of care and claims by language. This data is reviewed quarterly by its Provider Network Committee.	
Documentation Submitted as Evidence	Quality Management Language and Interpretive Data 2022	
HSAG Assessment of Resolution	The Quality Management Language and Interpretive Data 2022 example showed: • The number of members by spoken language. • The number of interpreter needs identified by language. • The "needs interpreter" claims by type of care (e.g., dental, mental, physical, total). • The interpreter data received and missing. • The claims by language. The CCO's IP response indicated that these data are reviewed quarterly by its Provider Network Management Committee (PNMC). HSAG requested and received the CCO's April 2023 PNMC meeting minutes demonstrating a review of the quality management language and interpretive data. This finding is **resolved**.	☒ Resolved ☐ Resolved, with recommendations ☐ Not Resolved

Standard V—Provider Selection	
Element #2	The CCO follows a documented process for credentialing and recredentialing of network providers. Documentation must include: a. Proof of professional liability insurance. b. Academic credentials and training received. c. Current, valid licenses and certifications. d. Results of exclusion and sanction searches. *42 CFR §438.214(b),(d)* *Contract: Exhibit B Part 4 (5)(a),(f-g)* *OAR 410-141-3510 (1)*
Finding: Although there was evidence of ensuring verification of liability insurance coverage through internal credentialing activities, documentation of subcontractor oversight of liability coverage verification was not addressed in any of the submitted documentation. This requirement was *Partially Met*.	
Required Action: CHA must update its monitoring procedures to ensure its credentialing subcontractors responsible are verifying providers' liability insurance coverage, and include appropriate documentation of this oversight.	

CCO Improvement Plan

CCO Action Plan/Interventions	Individual(s) Responsible	Completion Date
Updated language to PP09001-Delegated.Credentialing.01.25.22	Jeff Dover/ Shelley Emary	2/4/22

Documentation Submitted as Evidence	PP09001-Delegated.Credentialing.01.25.22	
HSAG Assessment of Resolution	CHA submitted its *Delegated Credentialing* policy, which included the provision of the delegated entity to ensure contracted providers/staff are credentialed in accordance with the *Credentialing* policy and asserted that CHA would conduct audits of the delegated entities credentialing files. CHA's *Credentialing* policy (submitted for Finding #16) listed all documentation to be maintained in credentialing files, including proof of liability insurance.	☐ Resolved ☐ Resolved, with recommendations ☒ Not Resolved

Standard V—Provider Selection		
	During the virtual onsite review, CHA reported annual oversight audits are completed of the delegated entity to assess for compliance. CHA did not provide evidence of communication with the delegated entity regarding the revised policy and expectations, revised audit tool ensuring verification of appropriate documentation during audits, or a completed audit conducted since the last annual CMR audit to demonstrate the CCO has resolved the issue. This finding remains **unresolved.**	
CCO Status Update	CHA disagrees with the finding, we have nothing further to submit and we consider this to be resolved because CHA performs a delegated entity audit of each applicable provider, where we send out our policies prior to the audit on an annual basis. CHA has already provided evidence of this to HSAG.	
Documentation Submitted as Evidence		
HSAG Assessment of Resolution	The CCO did not submit any documentation for this IP element with its initial submission. HSAG provided an additional opportunity for the CCO to resubmit documentation to demonstrate the resolution of this finding. HSAG specifically requested the following information: • The current delegated credentialing audit tool. • Copies of completed CY 2022 audits of delegates performing CCO-authorized credentialing. • Evidence that CCO audits include file reviews demonstrating that the delegated entity conducts verification of appropriate documentation (e.g., proof of professional liability insurance, academic credentials and training received, current/valid licenses and certifications, results of exclusions, and sanction searches). The CCO submitted copies of its 2022 delegated credentialing audits for BestCare, Klamath Basin Behavioral Health, Lutheran Community Services NorthWest and OnTrack. The audit tools included file reviews verifying the presence of:	☐ Resolved ☒ Resolved, with recommendations ☐ Not Resolved

Standard V—Provider Selection		
	• Proof of professional liability insurance. • Academic credentials and training received. • Current, valid licenses and certifications. • Results of exclusion and sanction searches. Audit results revealed numerous deficiencies with the subcontractors' files, including omissions of license verification, academic credentials, proof of liability insurance, and results of exclusion searches. The CCO's response to HSAG's request also indicated that the CCO ended all delegated credentialing agreements in 2023. During the site visit, HSAG recommended that the CCO review its processes and incorporate regular monitoring activities for providers credentialed internally to ensure compliance. This is particularly important given the CCO's decision to credential and recredential all providers internally. HSAG will perform a file review for the Provider Selection standard during the CY 2024 CMR to ensure files for providers credentialed and recredentialed during the review period include required element documentation. This finding is **resolved with recommendations**.	

Standard V—Provider Selection	
Element #3	When credentialing providers or provider types designated by CMS as "moderate," or "high-risk," the CCO demonstrates the provider has undergone a fingerprint-based background check and site visit withing the previous 5 years. For a provider who is actively enrolled in Medicare and has undergone a fingerprint-based background check as part of Medicare enrollment, this will be deemed to satisfy the requirement for OHA provider enrollment. *42 CFR §438.214(e)* *Contract: Exhibit B Part 4 (5)(b)*
Finding: Although CHA's *Credentialing* policy addressed moderate- and high-risk providers, its audit tool did not verify that this was addressed in subcontractor policies or that subcontractors verify enrollment with OHA prior to credentialing these providers. This requirement was *Partially Met*.	
Required Action: CHA's oversight tools and processes for credentialing subcontractors must include verification of a documented process for moderate- and high-risk providers and verification of OHA enrollment prior to credentialing.	

CCO Improvement Plan

CCO Action Plan/Interventions	Individual(s) Responsible	Completion Date
Language has been updated in the PP09002-Credentialing.Policy.01.26.22 policy.	Jeff Dover/ Shelley Emary	2/4/22

Documentation Submitted as Evidence	PP09002-Credentialing.Policy.01.26.22	
HSAG Assessment of Resolution	CHA submitted its *Delegated Credentialing* policy, which included the provision of the delegated entity to ensure contracted providers/staff are credentialed in accordance with the *Credentialing* policy and asserted that CHA would conduct audits of the delegated entities credentialing files. CHA's *Credentialing* policy included a process for identifying high and medium-risk providers and notifying the Compliance Officer to initiate the fingerprint based background check and site visit. During the virtual onsite review, the CCO reported delegated entities are required to follow CHA's credentialing policies and maintain documents within the files. CHA reported its audit of delegated entities includes verification of a documented process	☐ Resolved ☐ Resolved, with recommendations ☒ Not Resolved

Standard V—Provider Selection		
	for moderate- and high-risk providers and verification of OHA enrollment prior to credentialing. CHA did not provide evidence of communication with the delegated entity regarding the revised policy and expectations, revised audit tool ensuring verification of appropriate documentation during audits, or a completed audit conducted since the last annual CMR audit to demonstrate the CCO has resolved the issue. This finding remains **unresolved.**	
CCO Status Update	CHA disagrees with the finding. CHA provided evidence of this communication with follow up documentation post 2022 Audit. We have nothing further to submit and we consider this to be resolved because CHA performs a delegated entity audit of each applicable provider, where we send out our policies prior to the audit on an annual basis. CHA has already provided evidence of this to HSAG. If HSAG can clarify what is specifically required CHA can provide it.	
Documentation Submitted as Evidence		
HSAG Assessment of Resolution	The CCO did not submit any documentation for this IP element with its initial submission. HSAG provided an additional opportunity to the CCO to resubmit documentation to demonstrate resolution with this finding. HSAG specifically requested the CCO's current delegated credentialing audit tool and copies of completed CY 2022 element 2 audits of delegates performing credentialing on behalf of the CCO. For this element, HSAG also requested the following: • Evidence that the CCO audits of the delegated entity include verification of a documented process for moderate- and high-risk providers and verification of OHA enrollment prior to credentialing. This includes notifying the compliance officer to initiate the fingerprint-based background check and site visit. The CCO submitted completed audits for BestCare, KBBH, LCSNW, and OnTrack, which included requiring the delegated credentialing entity to perform background checks during initial credentialing and recredentialing. However, the audit tool did not address whether the CCO verified that the subcontractor had a documented process for moderate- and high-risk providers and verification of OHA enrollment prior to credentialing, including notifying the compliance officer to initiate the	☐ Resolved ☒ Resolved, with recommendations ☐ Not Resolved

Standard V—Provider Selection		
	fingerprint-based background check and site visit. However, the CCO's IP response also indicated that all delegated credentialing agreements ended in 2023. During the site visit, HSAG recommended that the CCO review its processes to ensure it has an effective process for moderate- and high-risk providers and verification of OHA enrollment prior to credentialing. This should include notifying the compliance officer to initiate the fingerprint-based background check and site visit to ensure compliance with the CY 2024 review of the Provider Selection standard. HSAG will ask the CCO to describe its process and demonstrate how moderate- and high-risk providers are identified and verified for OHA enrollment prior to credentialing and how fingerprint-based background checks and site visits are coordinated when applicable. This finding **is resolved with recommendations**.	

Standard V—Provider Selection			
Element #7	The CCO ensures that all participating providers providing coordinated care services to members are credentialed upon initial contract with the CCO and recredentialed no less frequently than every 3 years. *42 CFR §438.214(a)* *Contract: Exhibit B Part 4 (4)* *OAR 410-141-3510 (1)(a)*		
Finding: While CHA's credentialing policies were consistent with the requirement to recredential all contracted providers every three years, the record review revealed that two providers were recredentialed outside of the three-year cycle. For delegated credentialing, a sample monthly monitoring report showed inconsistent compliance with the three-year requirement. This requirement was *Partially Met*.			
Required Action: CHA must update its recredentialing processes (e.g., monitoring procedures, reporting) to ensure timely processing of its providers no less than every three years to the day and ensure that its subcontractors are also compliant with the time frame.			
CCO Improvement Plan			
CCO Action Plan/Interventions		**Individual(s) Responsible**	**Completion Date**
CHA currently does annual audits of any delegated subcontractor for the purposes of credentialing, language has been updated in the following P&Ps: PP09002-Credentialing.Policy.01.26.22 and PP09001-Delegated.Credentialing.01.25.22		Jeff Dover/ Shelley Emary	2/4/22
Documentation Submitted as Evidence	PP09002-Credentialing.Policy.01.26.22 and PP09001-Delegated.Credentialing.01.25.22		
HSAG Assessment of Resolution	CHA submitted its policies; however, the initial finding was related to non-compliance with the required 3-year time frame for recredentialing of providers by CHA and its delegated entities. During the virtual onsite review, CHA reported annual oversight audits are completed of the delegated entity to assess for compliance. CHA reported the delegated entity submits a monthly report of credentialed and recredentialed providers and timeliness of recredentialing is monitored by the CCO.	☐ Resolved ☐ Resolved, with recommendations ☒ Not Resolved	

Standard V—Provider Selection		
	Following the virtual onsite, CHA submitted sample credentialing/recredentialing reports from its delegated entity for July and August 2022 which demonstrated a three-year "to the day" time frame between the credential start date and credential expiration date. However, the Provider List spreadsheet dated 8/1/22 showed time frames longer than three years between the "Entity Credential from Date" to the "Entity Credential to Date" and the spreadsheet showed "Entity Credential To Dates" from January through July 2022, which indicates the providers have not been credentialed timely or the spreadsheet is not being updated regularly to capture credentialing dates. The following providers had dates outside the three-year credentialing time frame: • Hollander-Rodriguez (rows 46-49): 9/16/16 – 10/3/22 • Williams (rows 274-277): 8/4/16 – 8/1/22 • Smith (rows 748-750): 3/13/19 – 12/28/22 CHA must demonstrate monitoring timeliness of recredentialing to ensure compliance with the state-established recredentialing time frame of three years to the day internally and for all subcontractors performing delegated credentialing of physical, behavioral, and dental health providers. This finding remains **unresolved.**	
CCO Status Update	The Provider List spreadsheet dated 8/1/22 is the monitoring mechanism that CHA uses to identify providers outside the three-year credentialing time frame. This spreadsheet is updated monthly thus it is updated regularly to monitor credentialing dates.	
Documentation Submitted as Evidence		
HSAG Assessment of Resolution	The CCO did not submit any documentation for this IP element with its initial submission. HSAG provided an additional opportunity for the CCO to resubmit documentation to demonstrate a resolution to this finding. HSAG specifically requested the following:	☐ Resolved ☐ Resolved, with recommendations ☒ Not Resolved

Standard V—Provider Selection		
	• Evidence of CCO oversight of recredentialing timeliness for physical, behavioral, and dental health providers recredentialed between 9/1/22 and 4/1/23. • Actions that were taken to address recredentialing timeliness issues identified through monitoring. The CCO's response to HSAG's request indicated that the CCO ended all delegated credentialing agreements in 2023. However, the CCO was required to demonstrate compliance with the three-year credentialing cycle for providers recredentialed internally as well as those recredentialed by subcontractors. During the site visit, the reviewer discussed the specific requirement and the documentation needed to resolve the finding. The CCO reported that it is conducting monitoring activities. However, the CCO continues to have recredentialing time frames exceeding the three-year credentialing requirement. The CCO attributed this to challenges in receiving completed application packets from providers. This finding remains **unresolved**. HSAG recommends that the CCO review its internal processes and consider beginning the recredentialing process sooner, allowing sufficient time to conduct information verification through primary sources, verify sanction, review the credentialing application and associated provider-submitted documents, including liability insurance, and make final application determinations in the required time frame.	

Standard V—Provider Selection	
Element #9	If the CCO declines to include individual or groups of providers in its provider network, it must give the affected providers written notice of the reason for its decision. *42 CFR §438.12(a)(1)* *Exhibit B Part 4 (4)(a)(3)* *OAR 410-141-3510 (2)*
Finding: While CHA's *Fair Hearing* policy addressed provider denials and a template letter included all necessary information, the CCO was unable to demonstrate any subcontractor oversight of denials or provider notification for denials. This requirement was *Partially Met*.	
Required Action: CHA must ensure there is a process for subcontractors to inform the CCO of provider denials as well as to maintain oversight of the provider notification process, including a reason for the decision.	

CCO Improvement Plan

CCO Action Plan/Interventions	Individual(s) Responsible	Completion Date
Language has been updated in the Fair Hearing policy.	Jeff Dover/ Shelley Emary	2/4/22

Documentation Submitted as Evidence	PP09003-Fair.Hearing.01.25.22, PP09003.01-Fair.Hearing.01.25.22	
HSAG Assessment of Resolution	CHA submitted its revised *Fair Hearing* policy, which included provider notification of appeal decision. The *Delegated Credentialing* policy required delegated entities to follow the CCO's *Credentialing* policy, which included the provision to notify providers within five days of the credentialing decision and included the requirement of the delegated entity to notify CHA within 14 days of any credentialing denial. During the virtual onsite review, CHA reported the monthly credentialing report submitted by the delegated entity would indicate providers denied credentialing. Following the virtual onsite review, CHA submitted sample credentialing/recredentialing reports from its delegated entity for July and August	☐ Resolved ☐ Resolved, with recommendations ☒ Not Resolved

Standard V—Provider Selection		
	2022, which included a Provider Status column for the delegate to indicate a credentialing decision denial. However, the *Credentialing* policy asserted providers will be notified within five days of the decision to deny credentialing and delegated entities are to notify CHA within 14 days of any credentialing denial. A spreadsheet sent monthly would not meet the 14-day notification requirement. There was also no evidence or tracking the five-day requirement for notifying providers of the decision to deny credentialing. CHA must develop a process to oversee the delegated entities compliance with the requirement to inform the CCO of provider denials as well as to maintain oversight of the timeliness and completeness of the provider notification process, including a reason for the decision. This includes all delegated entities performing delegated credentialing for physical, behavioral, and dental health providers. HSAG recommends the CCO consider requiring the delegated entities to submit reports every 14 days and revising the spreadsheet to include columns for tracking date of credentialing decision denial, date of CCO notification, date letter mailed to provider, reason included in letter informing provider of denial. If CHA does not change the reporting frequency, the CCO must develop a process for the delegated entity to inform the CCO when there is a credentialing denial and also revise the spreadsheet to capture the information. HSAG also recommends CHA reviews its processes for providers credentialed internally to ensure compliance with the five-day notification to providers and the inclusion of a reason for the denial. The Provider List spreadsheet could be revised to include columns to capture the required information. This finding remains **unresolved.**	
CCO Status Update	CHA provided HSAG with the applicable policies and discussed them during the virtual on site at length. CHA has nothing more to submit.	
Documentation Submitted as Evidence		

Standard V—Provider Selection		
HSAG Assessment of Resolution	The CCO did not submit any documentation for this IP element with its initial submission. HSAG provided an additional opportunity to provide documentation to resolve the finding and requested the following: • Evidence of CCO oversight of the provider notification process for timeliness and completeness. This must include reason(s) for credentialing decision denials within five days. • CCO monitoring of its credentialing decision denial notifications performed in 14 days. The CCO's response to HSAG's request indicated that the CCO ended all delegated credentialing agreements in 2023. During the site visit, HSAG recommended that the CCO review its processes and incorporate regular monitoring activities for providers credentialed internally to ensure compliance with the five-day notification to providers. This must include the reason when the CCO denies a provider's credentialing application. HSAG will review files during the CY 2024 review of the Provider Selection standard to ensure providers denied credentialing by the CCO were provided written notification, including the reason for the denial, within five days of the CCO's decision. This finding is **resolved with recommendations**.	☐ Resolved ☒ Resolved, with recommendations ☐ Not Resolved

Standard V—Provider Selection			
Element #10	The CCO provides training for CCO staff and participating providers and their staff regarding the delivery of covered services, applicable administrative rules, and the CCO's administrative policies. *42 CFR §438.214(e)* *Exhibit B Part 4 (5)(k)* *OAR 410-141-3510 (1)(c)(B)*		
Finding: The CCO submitted adequate provider training materials regarding the delivery of covered services, applicable administrative rules, and the CCO's administrative policies along with evidence of tracking training completion for providers and provider staff members. However, no CCO staff training materials or evidence of training completion were submitted. This requirement was *Partially Met*.			
Required Action: CHA must ensure its staff training materials include delivery of covered services, applicable administrative rules, and the CCO's administrative policies. The CCO must also track the completion of training (e.g., via a spreadsheet, learning management software, or attestations).			
CCO Improvement Plan			
CCO Action Plan/Interventions		**Individual(s) Responsible**	**Completion Date**
Staff training is being created based on provider training and is slated for dissemination to all staff by end of Q2.		David Shute/ Arthur Petersen	6/2022
Documentation Submitted as Evidence			
HSAG Assessment of Resolution	CHA's IP indicated staff training was still under development at the time of IP submission. During the virtual onsite review, CHA reported training had been conducted. Following the virtual onsite review, CHA submitted a Case Management and Covered Services training deck and staff completion report. However, the training content was primarily focused on case management services and did not contain information regarding applicable administrative rules or the CCO's administrative policies.	☐ Resolved ☐ Resolved, with recommendations ☒ Not Resolved	

Standard V—Provider Selection		
	HSAG recommends CHA review the 2022 CCO contractual requirements for this element regarding training conducted as part of the credentialing process in Exhibit B, Part 4 (5)(i) which states the *Contractor shall provide training for Contractor staff and Participating Providers and their staff regarding the credentialing of Providers and the delivery of Covered Services, applicable administrative rules, and Contractor's administrative policies as set forth in Sec. 11, Para. b, Sub. Para. (8) of Ex. B, Part 9*. Content of training for the delivery of covered services should include the covered services outlined in the contract, including coordinated care services, applicable administrative rules, and administrative policies specific to those outlined in Exhibit B, Part 9 (11)(b)(8). This finding remains **unresolved.**	
CCO Status Update	Staff training is being updated is slated for dissemination to all staff by end of Q2. Draft has been included for review.	
Documentation Submitted as Evidence	Ex B, Pt 4	
HSAG Assessment of Resolution	The draft Ex B, Pt 4 PowerPoint presentation included information on covered services, including the Prioritized List of Health Services; OHP physical, behavioral, and dental health benefits; medication coverage; and applicable OARs. The slide for EPSDT included only a title page, did not look finished, and the presentation did not include information regarding care coordination. However, the CCO had previously submitted a Case Management and Covered Services slide deck, which focused on case management services. The CCO reported that its staff training should be complete by the end of Quarter 2 2023. During the site visit, the reviewer discussed the CCO's progress with training completion. The CCO reported that staff training has been postponed. Further, it seeks to combine the annual training in November or December 2023 to current staff with its onboarding training for new staff. The reviewer also inquired about the EPSDT slide and plans to incorporate the content from the Case Management and Covered Services slide deck with the newly developed training. The CCO reported	☐ Resolved ☐ Resolved, with recommendations ☒ Not Resolved

Standard V—Provider Selection		
	that its plan is to have all the information in one slide presentation, and the EPSDT slide will be expanded to include additional content regarding those services. This finding remains **unresolved**.	

2022 Findings

Standard IX—Enrollment and Disenrollment	
Element #2	The CCO does not discriminate against individuals eligible to enroll and will not use any policy or practice that has the effect of discriminating on the basis of health status or need for health care services, race, color, or national origin, religion, sex, sexual orientation, marital status, age, gender identity, or disability. *42 CFR §438.3(d)(3-4)* *CCO Contract Exhibit B Part 3(8)(c)*
Finding: CHA's *Enrollment and Disenrollment* policy and procedure stated the CCO shall not discriminate against individuals eligible to enroll on the basis of health status, the need for health care services, race, color, national origin, religion, sex, sexual orientation, marital status, age, gender identity, or disability, and shall not use any policy or practice that has the effect of discriminating on the basis of race, color, national origin, religion, sex, sexual orientation, marital status, age, gender identity, or disability**.** CHA's *Non-Discrimination* policy asserts members will not be discriminated against based on their race, ethnicity, color, national origin, citizenship, religion, sex, sexual orientation, gender, gender identity, age, physical or mental disability, or veteran status. However, CHA's *Non-Discrimination* policy does not address potential members/other individuals eligible to enroll. During the virtual "onsite" review, staff members discussed that members are informed of the CCO's policies regarding non-discrimination through its website and member handbook. CHA's member handbook communicated its policies regarding discrimination; however, the member handbook did not address discrimination on the basis of health status or need for health care services. CHA also demonstrated its *Non-Discrimination* policy is on its website. CHA described how staff members are informed of its policies regarding non-discrimination and asserted this information is contained within the employee handbook. As follow-up to the review, CHA provided a copy of its employee handbook, which informs staff members that discrimination between an employee and a third party, such as a customer, will not be tolerated. The employee handbook only addresses "customers" and does not address potential members/individuals eligible to enroll, nor discrimination on the basis of health status or need for health care services. This requirement was *Partially Met*.	
Required Action: CHA must update its documents provided to individuals eligible to enroll and the employee handbook or other materials utilized to train enrollment staff members on its policies to align with its internal policy and procedure as well as State and federal requirements, and to include the required language asserting the CCO does not discriminate against individuals on the basis of health status or need for health care services. If CHA uses the member handbook as a means to affirm its *Non-Discrimination* policy related to its enrollment practices, the member handbook must be revised to align with the State and federal requirements to assert the CCO does not discriminate against individuals eligible to enroll on the basis of health status or need for health care services, race, color, or national origin, religion, sex, sexual orientation, marital status, age, gender identity, or disability. However, as a best practice, CHA should provide this information to potential members using a more streamlined approach (i.e., single-page document or statement on website) to avoid information overload.	

Standard IX—Enrollment and Disenrollment			
CCO Improvement Plan			
CCO Action Plan/Interventions		**Individual(s) Responsible**	**Completion Date**
The 2023 approved CHA Member Handbook was creating using the Member Handbook template created by OHA and the proper verbiage has been included.		• Michael Donarski	Jan 2022
Documentation Submitted as Evidence	CHA Member Handbook 02 2023 page 10,		
HSAG Assessment of Resolution	The CCO has revised its 2023 member handbook to include the appropriate requirements. However, during the 2022 compliance review, the CCO identified the employee handbook as the documentation the CCO used to train enrollment staff on this requirement. The CCO was required to revise its employee handbook or other materials to train enrollment staff on the requirements to align with its internal policy and procedure and State and federal requirements. The employee handbook did not address potential members/individuals eligible to enroll, nor did the handbook address discrimination on the basis of health status or need for health care services. Post-site visit, the CCO confirmed that revisions to the employee handbook were not made. Instead, it asserted that in lieu of the revisions to the handbook, the CCO would provide the *Member Rights, Enrollment and Disenrollment, and Nondiscrimination* policies and procedures to member services staff upon hire and annually. To resolve this finding, the CCO must demonstrate training enrollment staff on this requirement. This finding remains **unresolved**.		☐ Resolved ☐ Resolved, with recommendations ☒ Not Resolved

Standard IX—Enrollment and Disenrollment	
Element #4	The CCO may **not** request disenrollment of a member because of an adverse change in the member's health status or because of the member's: a. Utilization of health services. b. Physical, intellectual, developmental, or mental disability. c. Uncooperative or disruptive behavior resulting from the member's special needs, disability or any condition that is a result of their disability. d. Being in the custody of DHS/Child Welfare. e. Prior to receiving any services, including, without limitation, anticipated placement in or referral to a psychiatric residential treatment facility. f. A member's decision regarding their own medical care with which the contractor disagrees. g. Filing a grievance or exercising any appeal or contested case hearing rights. *42 CFR §438.56(b)(2)* *OAR 410-141-3810(4)(c)* *CCO Contract Exhibit B Part 3(9)(d)*
Finding: CHA's *Enrollment and Disenrollment* policy asserted the CCO may not request disenrollment of a member for the appropriate reasons. During the virtual "onsite" review, CHA staff members discussed the CCO's process for ensuring CCO-initiated disenrollment requests were appropriate. CHA asserted the CCO conducts reviews of grievances to evaluate whether the disenrollment requests were appropriate. The CCO also discussed that its Operations Council reviews enrollment and disenrollment reports; however, the CCO did not provide evidence of this review. This requirement was *Partially Met*.	
Required Action: CHA must demonstrate it is regularly monitoring reasons for disenrollment, other than for the loss of eligibility, when disenrollment of members occurs. Evidence of monitoring may include standard reports and/or Quality Improvement Committee (QIC) meeting minutes that address enrollment changes, including whether or not disenrollment requests are received or initiated.	
CCO Improvement Plan	

CCO Action Plan/Interventions	Individual(s) Responsible	Completion Date
Starting in May, subcommittees will report out quarterly to QMC for guidance on activities related to the oversight needed. May will be Compliance and PNMC, June will be URC and P&T. Meeting Minutes have been enhanced to capture more details on recommendations from previous meetings.	• Michael Donarski	

Standard IX—Enrollment and Disenrollment		
Documentation Submitted as Evidence		
HSAG Assessment of Resolution	The CCO asserted that enhancements would be made to committee meetings. However, the CCO did not provide evidence of meeting minutes demonstrating that the CCO is regularly monitoring reasons for disenrollment other than for the loss of eligibility when member disenrollment occurs. The CCO must provide evidence of regularly monitoring the reasons for disenrollment, other than for the loss of eligibility, when member disenrollment occurs. Evidence of monitoring may include standard reports and/or Quality Improvement Committee (QIC) meeting minutes that address enrollment changes, including whether or not disenrollment requests are received or initiated. This finding remains **unresolved**.	☐ Resolved ☐ Resolved, with recommendations ☒ Not Resolved

Standard IX—Enrollment and Disenrollment	
Element #5	The CCO has a process that allows members to disenroll **without cause** for any of the following reasons: a. OHP clients auto-enrolled or manual-enrolled in error may change plans, if another plan is available, within thirty (30) days of the member's enrollment. b. Newly eligible members may change plans, if another plan is available within ninety (90) days of their initial plan enrollment. c. A member may request to change plans, after six (6) months of their initial plan enrollment. d. A member may request disenrollment during "OHP eligibility renewal," which is typically twelve (12) months. e. Full benefit dual eligible members and members who are American Indian/Alaska Native beneficiaries may change plans or disenroll to Fee-for-Service at any time. f. Upon automatic re-enrollment (e.g., a recipient who is automatically re-enrolled after being disenrolled, solely because such recipient loses Medicaid eligibility for a period of two (2) months or less), if the temporary loss of Medicaid eligibility has caused the member to miss the annual disenrollment opportunity. g. Whenever the member's eligibility is re-determined by OHA. h. When OHA has imposed sanctions on the CCO, including the suspension of all new enrollment (consistent with 42 CFR 438.702(a)(4). i. Members have one additional opportunity to request a plan change during the eligibility period if none of the above options can be applied *42 CFR §438.56(c)(2) and (g)* *OAR 410-141-3810(1)(b)(A)* *CCO Contract Exhibit B Part 3(9)(c)(1)(a)*
Finding: CHA's *Enrollment and Disenrollment* policy included the appropriate state-established without cause reasons for which a member can disenroll. CHA's member handbook provided to members in 2021 informs members that *American Indian members and Alaska Native members can join, change, or leave their CCO anytime. All other members can change at these times as long as another CCO in their area is open for enrollment:* • *You can change plans during the first 30 days after you enroll.* • *If you are new to OHP, you can change CCOs during the first 90 days after you enroll.* • *If you move to a place that your CCO doesn't serve, you can change CCOs as soon as you tell OHP Customer Service about the move.* • *You can change CCOs when you renew your OHP coverage. This usually happens once each year.* • *You can change CCOs if you have an important OHP-approved medical reason.* • *You can also change CCOs for any reason one time each year.*	

Standard IX—Enrollment and Disenrollment			
However, the member handbook does not address the following reasons: • After six months of initial plan enrollment. • Upon automatic reenrollment (e.g., a recipient who is automatically reenrolled after being disenrolled, solely because such recipient loses Medicaid eligibility for a period of two months or less), if the temporary loss of Medicaid eligibility has caused the member to miss the annual disenrollment opportunity. • When OHA has imposed sanctions on the CCO, including the suspension of all new enrollment (consistent with 42 CFR 438.702[a][4]). This requirement was *Partially Met*.			
Required Action: CHA must update its member handbook to align with state-established reasons members may request disenrollment without cause.			
CCO Improvement Plan			
CCO Action Plan/Interventions		**Individual(s) Responsible**	**Completion Date**
The 2023 approved CHA Member Handbook was creating using the Member Handbook template created by OHA.		• Michael Donarski	Jan 2022
Documentation Submitted as Evidence	CHA Member Handbook 02 2023 page 76,		
HSAG Assessment of Resolution	The CCO revised the member handbook to align with state-established reasons members may request disenrollment without cause. This finding is **resolved**.	☒ Resolved ☐ Resolved, with recommendations ☐ Not Resolved	

Standard IX—Enrollment and Disenrollment	
Element #6	The CCO has a process to allow members to disenroll **with cause** for any of the following reasons: a. The member moves out of the CCO's service area; b. The CCO does not, because of moral or religious objections, cover the service the member seeks; c. The member needs related services to be performed at the same time, not all related services are available from the CCO's plan, and the member's primary care provider (or another provider) determines that receiving the services separately would subject the member to unnecessary risk; d. Other reasons, including poor quality of care or lack of access to services covered under the contract or providers experienced with dealing with the member's specific needs. Examples include: • Services not provided in the member's preferred language; • Services not provided in a culturally appropriate manner; • It would be detrimental to the member's health to continue enrollment; • For continuity of care. *42 CFR §438.56(c)* *OAR 410-141-3810(1)(b)(B)* *CCO Contract Exhibit B Part 3(9)(c)(1)(b)*
Finding: CHA's *Enrollment and Disenrollment* policy included the appropriate state-established with cause reasons for which a member can disenroll; however, CHA's member handbook provided to members in 2021 does not inform members of the appropriate reasons to request disenrollment with cause. This requirement was *Partially Met*.	
Required Action: CHA must update its member handbook to align with state-established reasons members may request disenrollment with cause.	

CCO Improvement Plan

CCO Action Plan/Interventions	Individual(s) Responsible	Completion Date
The 2023 approved CHA Member Handbook was creating using the Member Handbook template created by OHA.	• Michael Donarski	Jan 2022

Standard IX—Enrollment and Disenrollment		
Documentation Submitted as Evidence	CHA Member Handbook 02 2023 page 75-76,	
HSAG Assessment of Resolution	The CCO revised the member handbook to align with state-established reasons members may request disenrollment with cause. This finding is **resolved**.	☒ Resolved ☐ Resolved, with recommendations ☐ Not Resolved

Standard XII—Quality Assessment and Performance Improvement	
Element #6	For CCOs providing long-term services and supports (LTSS), the CCO's QAPI program includes mechanisms to assess the quality and appropriateness of care furnished to members using LTSS, including: • Assessment of care between settings • A comparison of services and supports received with those set forth in the member's treatment/service plan, if applicable *42 CFR §438.330(b)(5)(i)* *OAR 410-141-3860(8)(d)*

Finding: CHA submitted its 2021 memorandum of understanding (MOU) with the APD partner, which outlined the mechanisms used to assess LTSS members' care between settings and members' services received compared to their treatment plans. The MOU included the monitoring processes and measures of success for each assessment area. Within the narrative for the 2021 MOU reporting document, the CCO asserted that within all domains there were areas where no collaboration or referrals between APD and the CCO occurred. CHA also indicated difficulty in reportability, largely due to the upgrade in its electronic health record (EHR) system, which was rolled out in May 2021. The CCO reported that, prior to that upgrade, there was no way to retrieve specific reporting data, such as collaborative Inter-Disciplinary Team (IDT) meetings, screening of LTSS members, referrals to APD, or the tracking of LTSS members and their real-time hospital/ED utilization. CHA reported it has implemented the following interventions to correct the issues identified in implementing its mechanisms:

- *Both Essette (CHA EHR) and Collective Medical now have LTSS flags embedded for ease of identifying high-risk members receiving services and supports.*
- *IDT meetings include "APD representative" in the attendee list.*
- *Case Management workflows are aligned to enhance reportability for IDT meetings which include APD, and for faxing care plans to providers on a regular cadence.*
- *Case Management workflows were improved during 2021 to assure that screening of members with LTSS was done in a reportable manner by opening members to the Screening model.*
- *A closed-loop referral process is under development that can be used by APD staff, Long-Term Care Community Nursing, and CCO Case Management.*

Within CHA's TQS, the CCO described its efforts to address the needs of LTSS full benefit dual eligible (FBDE) members by enhancing the coordination of care by (1) implementing a system flag to allow case managers to easily identify members receiving LTSS and (2) working to establish a LTSS cohort within the system to better track the LTSS population's utilization of services. CHA used HRAs to identify the needs of members receiving LTSS services and prioritize them accordingly; however, the CCO identified a need to increase the success rate of HRA screenings. Additionally, CHA identified a need to use current and new processes to improve data capture and reporting for quality and incentive metrics and other measures specific to the LTSS FBDE population to inform quality improvement and care coordination efforts. In 2021, CHA planned to use a LTSS FBDE quality dashboard to monitor the population and inform quality improvement efforts; however, CHA

Standard XII—Quality Assessment and Performance Improvement			
did not move forward with developing the dashboard as planned but did identify the measures to include and indicated within the TQS that the measures would be implemented by 2022. During the virtual "onsite" review, CHA indicated grievance and appeals were the primary mechanisms to identify the repetitive gaps in services for its membership receiving LTSS. This requirement was *Partially Met*.			
Required Action: CHA must demonstrate that its QAPI program includes mechanisms to assess the quality and appropriateness of care furnished to members using LTSS, including assessment of care between settings and comparison of services and supports received with those included in the member's treatment/service plan, if applicable			
CCO Improvement Plan			
CCO Action Plan/Interventions		**Individual(s) Responsible**	**Completion Date**
During 2022, QM worked with other internal teams (BI and CM) to implement the mentioned monitoring mechanisms within the MOU. Thus, ensuring appropriate reporting and accurate data for members receiving LTSS.		• Chanel Smith	
Documentation Submitted as Evidence	2023.CHA.TQS.Final.LTSS, B13.FINAL.ATRIO CHA Collaborative Workflow v1.2 (2023 TQS Submission), CHA LTSS Data - MOU LTSS 20221201 - deidentified, ATRIO.CHA.Collaboration.for.DSNP.LTSS.DP06018, CHA.Referrals.to.APD.DP06019, LTSS HEN.SNF Workflow v1.6		
HSAG Assessment of Resolution	The CCO provided evidence of enhancing the coordination of services for members receiving LTSS, such as developing workflow documents to coordinate with the APD. The CCO also provided reports demonstrating the data collected based on the measures identified in the MOU. However, the CCO did not demonstrate how the data are used in its Quality Assurance and Performance Improvement (QAPI) program to assess the quality and appropriateness of care provided. During the site visit, the CCO reported additional efforts to enhance care coordination with external partners. To resolve this finding, the CCO must demonstrate that the QAPI program includes mechanisms to assess the quality and appropriateness of care provided to members receiving LTSS. For example, evidence of analyzing the data in its QAPI program assessment would suffice. This finding remains **unresolved.**	☐ Resolved ☐ Resolved, with recommendations ☒ Not Resolved	

Standard XII—Quality Assessment and Performance Improvement	
Element #7	The CCO conducts and submits to OHA an annual written evaluation of the QAPI program and member care as measured against the written procedures and protocols of member care. The QAPI and member care evaluation includes the following: • Assessment of annual activities conducted, including background and rationale • Plan of ongoing improvement activities to address gaps, which will ensure quality of care for members and overall effectiveness of the QAPI program *42 CFR §438.330(e)(2)* *OAR 410-141-3525(11)(c)*

Finding: CHA's *QAPI* policy asserted the annual evaluation reviewed and reported on the following activities:

- *Oversight and activities of the Quality Management Committee (QMC).*
- *Oversight and activities of the Utilization Review (UR) Committee.*
- *Assessment of the quality and appropriateness of care furnished to all members, availability of services, second opinions, timely access and cultural considerations; the assessment will include a report of aggregate data indicating methods used to monitor compliance.*
- *Assessment of the quality and appropriateness of care furnished to members with special health care needs, including a report of aggregate data indicating the number of enrollees identified and methods used to evaluate the need for direct access to specialists.*
- *Demonstration of improvement in an area of poor performance in care coordination for members with SPMI, including a report of aggregate data indicating the number of members identified and methods used.*
- *Report on the grievance system including complaints, notice of actions, appeals and hearings, and including a report on the grievances and complaints of all subcontractors.*
- *Report on the monitoring and enforcement of consumer rights and protections within the Oregon Integrated and Coordinated Health Care Delivery System and demonstrating consistent responses to complaints of violations of consumer rights and protections.*
- *Demonstrated participation in OHA's Quality Health Outcomes Committee (QHOC) meeting.*
- *Review and assessment of the following:*
  - *CHA's performance toward the goals set forth by the TQS.*
  - *Overview of PIP activities.*
  - *Credentialing and Recredentialing process.*
  - *Performance on the OHA's Quality Incentive Metrics.*
  - *The data management system as it pertains to the generation of validated and actionable performance data.*

Standard XII—Quality Assessment and Performance Improvement			
– *Performance on the Medicare Advantage(MA) Stars measures.* – *Quality goals for the coming year.* – *Other significant activities of the department.* Although CHA indicated in its *QAPI* policy that the CCO would complete an evaluation with the aforementioned components, the CCO did not complete the annual evaluation described in its policy and only completed its TQS in 2021. CHA's TQS described the health plan's targeted interventions/projects, project components, project background/context and rationale, monitoring efforts, and future plans to address issues and improve performance for those projects. The TQS evaluation was limited in scope with a focus only on the TQS-required elements and did not include an evaluation of the program measured against the CCO's written procedures and protocols of member care. This requirement was *Partially Met.*			
Required Action: CHA must demonstrate compliance with the CCO's internal policies, including conducting an annual written evaluation of the QAPI program and member care as measured against the written procedures and protocols of member care, to include a plan of ongoing improvement activities to address gaps, which will ensure quality of care for members and overall effectiveness of the QAPI program.			
CCO Improvement Plan			
CCO Action Plan/Interventions		**Individual(s) Responsible**	**Completion Date**
During 2022, QM performed an analysis of the current QAPI program, along with the Policy & Procedures. A formal QAPI Workplan for 2023 will be developed and presented to QMC on March 2nd for final approval on May 4th. A QAPI Eval of 2022 program activity will also be completed for submission with TQS.		• Chanel Smith	
Documentation Submitted as Evidence	2023.CHA.QAPI.Plan.DRAFT, A2.2023.CHA.QAPI.Impact Analysis		
HSAG Assessment of Resolution	The CCO provided its 2023 QAPI Plan, which included an evaluation of the QAPI program measured against the CCO's procedures and protocols of member care. The QAPI Plan assessed the overall effectiveness of the QAPI program and included a plan of ongoing improvement activities to address gaps. HSAG recommends that the CCO ensure that the assessment aligns with the QAPI program components outlined in the standard and also identified in its QAPI program description, as this will be assessed during the subsequent compliance review for this standard. Additionally, the	☐ Resolved ☒ Resolved, with recommendations ☐ Not Resolved	

Standard XII—Quality Assessment and Performance Improvement		
	CCO should ensure its assessment includes trending data to assess improvements, ensure the results are reviewed by its QIC, and that those results are used to revise its QAPI program structure. This finding is **resolved with recommendations**.	

Standard XII—Quality Assessment and Performance Improvement	
Element #8	The CCO has a Quality Improvement (QI) committee that meets the following requirements: • Membership includes, at a minimum, the Medical/Dental Director, the QI Coordinator, and other health professionals who are representative of the scope of the services delivered • Maintains oversight and accountability of any delegated functions • Approves the annual quality strategy and retains oversight and accountability of quality efforts and activities performed by other CCO committees • Meets at least every two months and records minutes that include committee deliberations, recommendations regarding corrective actions to address issues identified, and review of results, progress, and effectiveness of corrective actions recommended at previous meeting *OAR 410-141-3525(11)* *CCO Contract Exhibit B Part 10(2)(c)(2)*
Finding: As described above, the *QAPI* policy described CHA's QMC as responsible for oversight of the QAPI program, with other committees and departments including the UR committee, Quality Management department, Case Management department, Provider Network Management Committee (PNMC), Compliance department, Operations Council, and Executive Approval Committee (EAC) being responsible for other quality assurance activities, as appropriate. CHA reported that quality improvement oversight was not isolated in a single group but stratified across the other committees; however, the State regulations require the QMC to maintain oversight and accountability of quality efforts and activities performed by other CCO committees. The QMC Charter described that the membership included at least five but no more than 15 external parties including contracted providers, including at minimum one physical health care provider, one behavioral health care provider, and one dental provider; partner organization administration staff, including behavioral health and dental; chief medical officer (CMO); director of quality management; quality management staff; and additional CHA staff as deemed appropriate. Meeting minutes demonstrated attendance of the appropriate staff and frequency of meetings. Meeting minutes also demonstrated the discussion of quality activities; however, deliberations were limited, with brief discussions, and many of the items only stating, "overview discussed." Although limited in detail, meeting minutes demonstrated review of results and progress, and minutes from the February, August, October, and December meetings demonstrated that recommendations regarding corrective actions to address the identified issues were made; however, the effectiveness of the corrective actions recommended at previous meetings was not discussed. Additionally, the committee meeting minutes did not demonstrate oversight and accountability of any delegated functions or approval of the annual quality strategy/QAPI policy/QAPI program description. This requirement was *Partially Met*.	
Required Action: CHA must ensure its QMC maintains oversight and accountability of any delegated functions, quality efforts, and activities performed by other CCO committees*;* approves the annual quality strategy; and records minutes that review the effectiveness of corrective actions recommended at previous meetings.	

Standard XII—Quality Assessment and Performance Improvement			
CCO Improvement Plan			
CCO Action Plan/Interventions		**Individual(s) Responsible**	**Completion Date**
QAPI EQR findings were discussed with QMC at the February 2023 meeting where the improvement plan was reviewed and feedback was provided. In March 2023, CHA's QAPI Plan was reviewed by QMC and will be Approved at the May 2023 meeting. Starting in May, subcommittees will report out quarterly to QMC for guidance on activities related to the oversight needed. May will be Compliance and PNMC, June will be URC and P&T. Meeting Minutes have been enhanced to capture more details on recommendations from previous meetings.		• Chanel Smith	
Documentation Submitted as Evidence	02.02.23.QMC.Minutes,03.02.23.QMC.Minutes		
HSAG Assessment of Resolution	The CCO provided its meeting minutes for the QMC meetings conducted in February and March 2023. The CCO reported that the March 2023 meeting included a QAPI Plan review and that the committee would approve the plan in May. However, the meeting minutes did not demonstrate a review, and the CCO did not provide May 2023 meeting minutes for review. Additionally, the QMC meeting minutes that were provided lacked detail and did not demonstrate that the QMC maintains oversight and accountability of: • Any delegated functions, quality efforts, and activities performed by other CCO committees. • The annual quality strategy approval process. • Recorded minutes that review the effectiveness of corrective actions recommended at previous meetings. The CCO was offered an opportunity to provide additional QMC meeting minutes after the site visit. However, the CCO submitted Utilization Review Committee meeting minutes, which do not meet this element's intent, requiring the quality improvement committee to provide oversight. To resolve this finding, the CCO must demonstrate that the QMC maintains oversight and accountability of any delegated		☐ Resolved ☐ Resolved, with recommendations ☒ Not Resolved

Standard XII—Quality Assessment and Performance Improvement		
	functions, quality efforts, and activities performed by other CCO committees, annual quality strategy approval, and recorded minutes that review the effectiveness of corrective actions recommended at previous meetings. This finding remains **unresolved**.	

Standard XIII—Health Information Systems	
Element #6	The CCO's health information system collects, analyzes, integrates and reports **service data** including the following: a. Services provided to members for pharmacy services. b. Covered services provided to members, through encounter data system or other documentation system. c. All data required to be reported in connection with encounter data reporting. d. Copies of completed request for long-term psychiatric care (LTPC) determination forms. *42 CFR §438.242(b)(2)* *CCO Contract Exhibit J(1)(a)*
Finding: CHA submitted several procedures (i.e., *MedImpact NCPDP Transfer, Encounter Claims Submission, Encounter Claims that Reject State Translator, Encounter Data Pend, Encounter,* and *Data File Generation Balancing Process)* that outlined the regulatory requirements and operations which supported the collection of clinical data for all services (including pharmacy) as well as the data elements needed to support encounter data reporting. CHA also provided process and systems flows (i.e., *Life of a Claim)* that addressed the collection, processing, and integration of health care services data from providers. CHA's responses in the ISCAT and to questions during the virtual "onsite" review described its processes to ensure that complete and accurate data were being submitted to OHA. All services, covered and uncovered, were processed through incoming claims and encounters (from delegated vendors) and output to OHA as encounters based on established policies, procedures, and desk-level processes. Additionally, demonstrations during the virtual "onsite" review confirmed the ability to collect, analyze, integrate, and report service data through CHA's processing of claims and encounter data. Incoming claims data were processed and translated into encounters through Quantum Choice, while pharmacy encounter data were retrieved and processed from its delegate. CHA did not provide any documentation to support the collection of completed requests for LTPC determination forms, nor were staff able to describe the systems or operational areas responsible for managing these data. During the virtual "onsite" review, CHA noted that it would not receive LTPC approval from the State and, as a result, would not capture this information. This requirement was *Partially Met*.	
Required Action: CHA must develop policies and procedures to support the collection and retention of completed LTPC forms when required. For example, CHA could expand its *Behavioral Health Community Mental Health Program (CMHP) Policy and Procedure* to outline requirements for the use, collection, and storage of LTPC forms in coordination with the management of members' services within its systems (e.g., *Essette*) or its delegates' systems.	

Standard XIII—Health Information Systems			
CCO Improvement Plan			
CCO Action Plan/Interventions		**Individual(s) Responsible**	**Completion Date**
CHA has an existing P&P (BH.Long.Term.Psychiatric.Care.PP15016) to support this information.		• Heather Robinson	
Documentation Submitted as Evidence	BH.Long.Term.Psychiatric.Care.PP15016		
HSAG Assessment of Resolution	The CCO provided its *Behavioral Health Long Term Psychiatric Care Policy and Procedure* (approved 01/2020; revised 05/2022) that outlined the regulatory requirements for managing the admission, discharge, and transition to/from LTPC facilities as well as the associated procedures for determining LTPC eligibility and placement. Additionally, the document included a Records Management section requirement that "team members must maintain all records relevant to administering this policy and procedure in the recognized record management system." However, the CCO's policy did not define the specific record management system used to store LTPC determination forms, nor did the CCO provide evidence of or demonstrate the storage of LTPC determination forms. During the site visit, the CCO confirmed that the record management system for storing LTPC determination forms is Essette. HSAG was able to view the data system and record documentation elements during the Coordination and Continuity of Care interview session. This finding is **resolved**.		☒ Resolved ☐ Resolved, with recommendations ☐ Not Resolved

Standard XIII—Health Information Systems	
Element #7	The CCO's health information system collects, analyzes, integrates and reports Measures and Outcomes Tracking System (MOTS) data. *CCO Contract Exhibit J(1)(a)*
Finding: CHA submitted its *Behavioral Health Community Mental Health Program (CMHP) Policy and Procedure* that outlined data reporting requirements for the CCO's contracted behavioral health partners. Further, the *Monitoring and Outcomes Tracking System* section of this policy stated that the CCO's community behavioral health partners would enroll and maintain member data in MOTS, including the establishment of enrollment and reporting time frames defined in OHA requirements. However, neither the policy nor discussions during the virtual "onsite" review addressed how the CCO conducts oversight of its behavioral health providers to ensure compliance with contract requirement (reporting, subcontractor or provider contract provisions, etc.). This requirement was *Partially Met*. **Note:** In coordination with OHA, CCOs were not assessed for their ability to collect, integrate, analyze, or report MOTS data within the CCO's HIS.	
Required Action: CHA must update its behavioral health policy to define mechanisms to ensure behavioral health provider compliance with MOTS reporting requirements and implement those procedures into its operations and oversight practices.	

CCO Improvement Plan

CCO Action Plan/Interventions	Individual(s) Responsible	Completion Date
CHA leadership has created a MOTS data utilization and monitoring project to utilize information technology. CHA has requested MOTS data from the state of Oregon. Data sharing agreements with BH providers need to be in place before data will be shared by OHA. Once in place, CHA will request MOTS data from the state and compare with claims data from BH providers to assess completeness. The data will be analyzed for quality improvement opportunities. Feedback to providers will be supplied.	Heather Robinson	Estimated end of 2023

Documentation Submitted as Evidence	**Original Submission –** MOTS Data Dictionary and Business Rules, FW_ MOTS Report Requests Received, FW_ MOTS Data Dictionary and Business Rules **Pre-Site Visit Submission (7/17/23)** – Community.Mental.Health.Program.PP11008	
HSAG Assessment of Resolution	The CCO provided email communications and a description of a proposed MOTS data utilization and monitoring project. The documentation described a process for requesting MOTS data from the State to be used to compare MOTS data with CHA claims data to determine the completeness of data submitted by the CCO's contracted BH providers. The CCO documented its implementation of the plan by including a copy of OHA's data dictionary (i.e., MOTS Data Dictionary and Business Rules), an	☐ Resolved ☒ Resolved, with recommendations ☐ Not Resolved

Standard XIII—Health Information Systems		
	email communication requesting MOTS data (i.e., FW_ MOTS Report Requests Received), and an internal request to add "a formal project" (i.e., FW_ MOTS Data Dictionary and Business Rules) to address a monitoring approach. However, none of these documents provided evidence of policies, procedures, or processes implemented by the CCO to monitor the submission and address the corrective action. In advance of the site visit, the CCO provided a copy of its *Behavioral Health Community Mental Health Program Policy and Procedure* to support its monitoring of MOTS data submission. However, the policy did not include any changes from the policy submitted in 2022, nor did it address the proposed monitoring approach referenced in the CCO's original IP submission. During the site visit, HSAG reviewed and discussed the status of the CCO's implementation of its MOTS monitoring procedure. The CCO stated it has worked with its BH providers to obtain the necessary data use agreements and has established preliminary data extraction queries with OHA. Moreover, it is currently using its BH Manager and staff to follow up with BH providers during ongoing outreach activities. The CCO noted it is currently working on defining reporting requirements to formalize and document its processes. The CCO provided a copy of its Project Plan (i.e., MOTS Oversight Project) to demonstrate implementation. However, the document was incomplete, with dates, tasks, and implementation data undefined. This finding is **resolved with a recommendation**. **Recommendation:** Once the oversight procedures and reporting structure are finalized, the CCO should formally document the process in its existing policies and procedures (e.g., the *Behavioral Health Community Mental Health Program Policy and Procedure*) or develop a new policy and procedure that outlines the steps used in its MOTS submission oversight. Additionally, HSAG recommends that the CCO fully populate its implementation plan with defined tasks and due dates to ensure successful project implementation and completion. Please note that during the 2025 CMR audit, the CCO will be required to provide copies of its updated policies and/or newly documented procedures that outline its monitoring approach and evidence of ongoing reporting, monitoring, and follow-up.	